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ORIGINAL COMMUNICATIONS.

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JOURNAL OF
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Original Communications.

REMARKS UPON THE MICROBACILLUS OF SEBORRHEA (SABOURAUD)—PRELIMINARY REPORT UPON AN EXAMINATION OF THE SEBACEOUS GLANDS OF THE NOSE.

BY JAY F. SCHAMBERG, A.B., M.D.,
Professor of Diseases of the Skin in the Philadelphia Polyclinic and College for Graduates in Medicine.

IN 1894, Unna, Engman and Hodara described a minute bacillus which they found constantly in comedones, and which was regarded by them as the cause of blackheads and of acne. In a histologic and bacteriologic description of comedones, they state that in the external layers of the comedo are found micrococci and the bacillus asciformis (flaschen bacillus), and that in the center myriads of microbacilli swarm. Unna, in his "Histopathology of the Skin" (page 350), says: "In the interior we find a special form of bacillus. We are particularly interested in the latter, inasmuch as it is, with the greatest probability, not only uniformly associated, but the true cause of the comedo formation and consequently of acne. The strongest proof of its etiologic significance, as far as histology goes, is in its relationship to suppuration of the comedo. The secondary and unessential pus formation in acne is not caused by an accidental contamination with pus cocci, but through the organism whose constant presence in the base of the comedo stamps it as its probable cause."

Microbacilli in the Sebaceous Glands of the Nose.

About a year ago, while examining the sebum from the sebaceous

follicles of the nose, I noticed an organism therein which was apparently identical with that described by Unna and his confrères. On looking up the subject I found that Sabouraud had previously noted its presence in the follicles of this region, and had remarked upon the identity of this organism with that of Unna. In order to determine its frequency, I examined fifty subjects, some perfectly healthy individuals and others suffering from various cutaneous diseases, presenting themselves at the Polyclinic Hospital. A little sebum was squeezed out from the nasal follicles, spread between two cover-glasses and stained with Loeffler's methylene blue and gentian violet. The condition of the skin of the nose, whether oily or dry, was noted in each instance. The results are herewith subjoined: Bacilli were present in 45 cases and absent in 5; they were present, therefore, in 90 per cent. of the patients examined:

27	positive cases, skin oily.
16	" " " dry.
2	" " not determined.
—	
45	
3	negative cases, skin dry.
2	" " " oily.
—	
5	

In the negative cases there was some difficulty in getting a sufficient amount of sebaceous material. No re-examinations were made.

The bacilli were present in masses of thousands, and represented practically pure cultures. They varied from 1¼ to 1½ m. in length and ⅓ to ½ m. in width; they were easily stained with aniline dyes, but were decolorized by acids.

Stained with Loeffler's methylene blue or thionin, they were very minute. They were about one-third larger when colored with gentian violet, owing to the staining of the surrounding capsule. They were not decolorized by Gram's method.

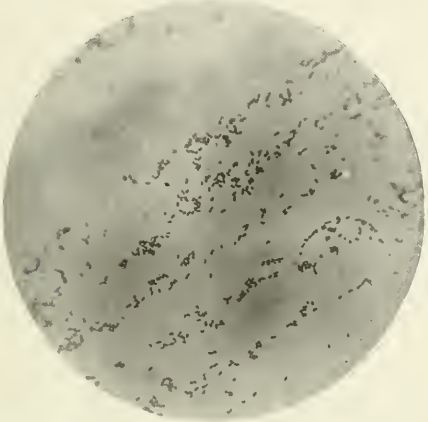
Efforts to artificially cultivate this bacillus failed. After trying all the ordinary media, I employed sterilized butter, and a combination containing chloride of sodium, phosphate of sodium, lanolin, etc., to approximate the constitution of human sebum, but without success.

Microbacillus of Seborrhea.

Sabouraud has made a most elaborate study of this bacillus, which

he designates as the "microbacillus of seborrhea." He has succeeded in growing it upon a special medium, after fifteen months of experimentation. In regard to seborrhea, he says: "The primary lesion of seborrhea is characteristic; it is the fatty cylinder in each pilary orifice, which pressure forces out. The seborrheic flux, in any given region, is the consequence of the elementary lesion just described, when it exists in myriads." This "seborrheic vermiform filament" is the forerunner of the comedo. Examined under the microscope, this filament contains

FIG. I.



Microbacillus found in follicles of the nose. (Sabouraud's microbacillus of seborrhea. Bacillus of acne, Unna, Engman, Hodara.) Bacilli and capsule stained with gentian violet.

millions of microbacilli. "It is, at the same time, the purest and the most abundant cutaneous infection known."

Comedo and Acne.

Sabouraud likewise regards this organism as an accessory, and, even at times, the exciting cause of acne.

"In all forms of acne, the seborrheic microbacillary filament is, in point of time, the first lesion. For there is no acne without pre-existing seborrhea."

In order for seborrhea to become acne, in order that the elementary

lesion of seborrhea may become that of polymorphous acne, a transformation is necessary, the cystic transformation which makes of the seborrheic filament a comedo."

The formation of the acne papule and pustule is due to secondary infection with staphylococci. Suppuration may, however, result at times without such secondary infection. "One is thus persuaded to ask whether, in some cases, acne suppuration is not purely microbacillary."

Baldness.

For Sabouraud, baldness is also due to this microbacillus, although he recognizes predisposing causes. He says:

"I have never seen grave baldness develop in a subject in whom the urologic curve was normal." (The typical urologic curve of baldness, according to Sabouraud, shows hyperacidity, hyperchloruria, and hypophosphaturia, the last named condition being the most constant.) "But I have never seen either a baldness which was not microbic, and which did not present the same microbe, an only microbe, always present in the follicle from which the hair falls."

"True baldness is seborrheic. Finding the microbe of seborrhea on the scalp of all bald persons proves bacteriologically the identity of oily seborrhea in all of the regions that it may occupy."

Microbacillus of the Peladic Utricle.

Several years ago Sabouraud wrote in the following manner concerning the bacillus which he found in alopecia areata:

"Moreover, there rests against the pathogenic rôle of this microbe a sufficiently strong objection to arrest a conviction, until certain proofs are established, which I cannot yet bring to bear. There is a known microbe in a common human affection, which I have not been able, either by its form, proportions, or methods of staining, to differentiate with certainty from the microbe of the peladic utricle; it is the microbe discovered by Unna, Engman and Hodara in the *comedo of acne*. I have a thousand times verified after them the existence of this in the comedo. The fact is indisputable. I have sought to differentiate by every means this microbe from the microbacillus of the peladic utricle. Their differences, without being negligible, are scarcely sufficient to permit me to affirm their duality." Sabouraud then details the following differences: The microbacillus of the peladic utricle appears to him to be a little smaller in all of its proportions, less regular in form, and often curved in the form of a comma or in a sigmoid manner.

Lustgarten's stain for the syphilis bacillus colors the comedo bacillus but not the peladic microbe. Sabouraud hastens to add that this differentiation can scarcely by relied upon, as decolorization, or the retention of color, depends upon the duration of immersion in the sulphurous solution.

To the unbiased reader and observer, it is evident that the microbacillus described by Unna, Engman and Hodara, and the peladic microbacillus described by Sabouraud, are one and the same organism. Their anatomical situation in the utricle or dilated summit of the hair follicles is identical both in the alopecia areata and in ordinary baldness. This can be verified by reference to Sabouraud's lithographic plates illustrating his articles on alopecia areata (*Annales de Derm.*, etc., Tome VII.), and his illustrations of the anatomy of "Calvitie" or baldness (*Les Maladies Seborrhéiques*, 1901). Furthermore, there are no reliable means of differentiating morphologically or tinctorially the microbacillus of seborrhea from that of alopecia areata. It is evident from a perusal of Sabouraud's articles that he regards the microbacillus under consideration as the cause of seborrhea, the cause of ordinary baldness, an essential accessory cause of acne, and occasionally the exciting cause of the last named disease. It is furthermore obvious that the "microbacillus of the peladic utricle," which Sabouraud described as the cause of alopecia areata, is, beyond reasonable doubt, the same organism as that which he alleges to produce ordinary alopecia. Seborrhea, acne, ordinary baldness and alopecia areata are, therefore, according to Sabouraud, produced by the same germ. What is it that causes the germ to produce one affection in one individual and another disease in another? Why should alopecia areata occur in one patient, and progressive baldness in another? Why should young women suffer from acne, and not from baldness? It would seem the easiest matter in the world for the microbacilli to be transplanted from the face to the scalp. I presume the answer is that the soil determines whether the germ shall grow, flourish and produce its pathogenic results in one region or another. I am of the opinion that the microbacillus described by Unna and Sabouraud may be found in the sebaceous follices of the nose, and perhaps elsewhere, in 90 per cent. or more of adults. Sabouraud would doubtless reply that almost every one suffers from seborrhea of the nose. If the presence of vermiform sebaceous filaments in the skin constitute seborrhea, then this statment is true. It may be well, however, to call attention to the fact that in sixteen of the individuals in whom I found microbacilli the skin of the nose at the time of examination was dry and not oily. Heretofore, dermatologists have recognized two

forms of seborrhea, *seborrhea oleosa* and *seborrhea sicca*. Sabouraud denies the existence of the latter condition.

If microbacilli are present in millions in the sebaceous glands of the nose in nearly all adults, it is not surprising that they should constantly be found in comedones, and frequently in the hair follicles of the scalp. Sabouraud first found them in alopecia areata, and more recently in ordinary baldness. It will be interesting to determine whether they cannot be found in other conditions.

Are all individuals in whom microbacilli are found protected against acne, baldness and alopecia areata by reason of the fact that they present an unfavorable soil for the growth and development of this bacillus? If this were true, it would indicate that only a very small percentage of the carriers or hosts of this organism were susceptible to its ravages. Moreover, the vast majority of people, in addition to this minute bacillus, have staphylococci present upon the skin. They have, therefore, both of the germs which determine an acne. If they are protected by the absence of favorable soil, then the general predisposing causes of acne are of preponderating importance and the presence of the exciting organisms of secondary significance.

In the sebaceous follicles of my own nose, and in those of various members of my family, I have repeatedly found myriads of microbacilli. I believe most physicians will be able to verify this observation in their own households.

Sabouraud explains the origin of microbacillary infection in the following manner: By chance contact, such, for instance, as might occur in kissing, the bacillus passes from one individual to another It may or may not find a favorable soil (*"terrain propice"*). If it does find it, it multiplies in the sweat, and the sebum is exuded upon the surface of the skin. It multiplies until it reaches the orifice of a follicle in which its generations can live.

"The microbacillary infection once established in the follicle, is invariably accompanied by three symptoms: the seborrheic flux, the falling of the hair in the infected follicle, and the hypersecretion of the sweat-glands in its neighborhood." One must admire the industry and the close powers of observation which have enabled Sabouraud to elaborate the fascinating theory which he presents in his recent most interesting work, "Les Maladies Seborrhéiques." It appears to me, however, that the evidence presented as to the parasitic nature of seborrhea, acne and baldness, is by no means conclusive. It has not been definitely proven that the microbacillus described by Unna and Sabouraud is not a more or less normal resident of large sebaceous glands.

RELATIVE IMPOTENCY DUE TO CHRONIC URETHRITIS OF THE POSTERIOR URETHRA.

By Louis E. Schmidt, M.Sc., M.D.,
Chicago, Ill.

IT has been repeatedly stated, and it is a fact, that impotency is often caused by chronic urethritis. This frequent assertion, however, rarely takes into consideration the individual causative conditions, and the different varieties of this disease which may occur.

It is desirable to draw attention to a special type of chronic urethritis of the posterior urethra, which causes a peculiar kind of passing (non-permanent) or relative impotency. We find individuals who, after having observed themselves closely for some time, find that the ability to have repeated intercourse within a short period of time is greatly increased, others again that the sexual feelings have become much more marked.

In both of these types we find the coincidence that the changes in the sexual powers and sensations soon follow in a slight varying period of time the acqusition of a gonorrhea.

In the first group of cases we see, at least for a short time, complete impotency, which is followed in the course of time by greatly reduced sexual powers.

The second group gives symptoms which are most peculiar. After a period of reaction in these individuals, during which normal erections occur, we find that the sexual feeling is changed into a most painful condition, in which the ejaculation is but an occurrence, and which is accompanied with severely painful sensations. These particular individuals avoid and fear every opportunity of sexual excitment and fear much more the sexual act. Partly due to local causes, partly due to the psychical impressions, we find that the erections become very few and that in case of sexual congress the act remains incomplete. In such affected individuals frequently phenomena arise. We find that during long-continued intercourse no ejaculation whatsoever occurs, even if slight sexual sensations are noticeable.

Impotency, when not due to atrophy of the seminal apparatus, is usually caused by pathological changes in the prostate gland. In this variety of impotency there is marked condition differing from those caused by any prostatic changes. In those cases of impotency produced

by prostatic pathological conditions, we find it characteristic that ejaculations are incomplete and insufficient.

The local findings are characteristic in the types to which we have reference.

In the first mentioned cases the caput gallinaginis is apparently enlarged, rounded out, the mucous membrane of a bluish-red color, the prostatic sinus greatly injected. In cases of the second type, the inflammatory signs are still more prominent. The adjoining part of the veru montanum also shows signs of inflammation. The usual slit-like openings of the ejaculatory ducts, which are upon or within the margin of the sinus pocularis, show a peculiar rounded and prominent form, still easily recognizable, yet the surrounding affected mucous membrane causes their apparent displacement.

The therapy can be successful only, and experience shows this to be true when the area affected is treated directly under control of the eye; in other words, when the treatment is undertaken with the aid of the urethroscope. It is of paramount importance, previous to the commencement of treatment, to be positive whether we are dealing with an acute inflammation or whether the chronic condition has set in. In the former case, the treatment must be more of a general character, that is, depletetory and antiphlogistic. In the latter type we can immediately commence with the urethroscopic treatment.

It is well understood that the posterior urethra is sensitive to instrumentation, and, as we may easily imagine, especially so when we introduce straight and large caliber instruments. For this reason it often desirable, and in some cases imperative, to use a local anesthetic. This can be done in two ways; we either introduce into the rectum, ten minutes previous to the urethroscopy, a quarter-grain morphine suppository, or, if the patient is especially sensitive, instillate into the posterior urethra five to ten minims of a two-per-cent. cocaine solution with a Guyon capillary catheter and syringe. In order to insure complete anesthesia of the parts, it is necessary, in a limited number of cases, to free the mucous membrane of the posterior urethra from the secretions, which often times cling tenaciously to these parts. This is best done with the aid of a soft rubber catheter and large syringe, with which we irrigate the parts thoroughly. Then we make the application of the local anesthetic. The treatment consists of the direct application to the caput gallinaginis and adjoining parts of iodine-glycerin solution. The treatments are first made with weak solutions, and then slowly increased in strength. The weak solution can be used freely, and the parts thoroughly "touched up" daily. As we reach the strong solution, we use less in quantity and make less frequent applications;

sometimes it is necessary to allow seven to ten days to intervene when using the strong iodine-glycerin solution. The interval varies according to the reaction. During the entire period of treatment the patient must be impressed with the importance of complete avoidance of sexual excitement, certainly of all attempts at the sexual act.

After the disappearance of the inflammatory swelling, provided no complication is present, we may expect complete return of the sexual function and sensations.

NEW TISSUE FORMATION IN THE URETHRA, ITS EARLY DETECTION AND PERMANENT OBLITERATION.*

By J. Henry Dowd, M.D.,
Buffalo, N. Y.

EVEN at this late date it is an open question as to whether new tissue (the first step towards stricture formation), and especially after it reaches a certain stage, can be completely and permanently eradicated. Fully 98 per cent. of all new tissue formation in the urethra is due to gonorrheal inflammation, which, if a little care is exercised, is detectable before firm cicatrices develop, and even after such has occurred it is possible to cause their entire disappearance.

Taking a case of acute inflammation, from its incipiency, we find the following:

Acute inflammation of the whole membrane, as far as the submucous tissue.

This runs a course more or less prolonged, ending in about six or eight weeks, either in complete resolution, or a chronicity develops, varying in degree from involvement of the whole membrane to only localized spots, the remaining membrane being in an almost normal condition.

Even though the former seems to persist, if irritation is avoided (this being the great cause of continued chronic urethritis), and the case left to Nature alone, sooner or later the membrane will assume a normal condition except at certain spots, these being situated at the most vascular and dependent portions of the canal, or where injury may have been done by our treatment with instruments, etc. One other factor is important as a causative agent: internally we find the

*Presented at the Pathological Section of the Buffalo Academy of Medicine, January, 1902.

circular muscles, whose function, together with the longitudinal layer, completely empty the urethra of every drop of urine. When inflammation has existed long enough to produce a marked cellular proliferation, the infiltrated muscles lose, to a certain extent, their contractility and the last few drops of urine, owing to a lack of propulsive force, adhere at the point of diminished power, *i.e.*, where the chronic inflammatory area exists.

Unless appropriate treatment is now instituted to bring about resolution in these spots, it will be found in time they will pass through the following course:

Cellular infiltration.

Cell proliferation.

New tissue formation, resulting in cicatricial tissue or stricture.

It is the detection of these chronic inflammatory areas with the promotion of absorption that prevents the last-named result.

As resolution ensues from the acute condition, it is seen that after discharge has ceased for several days, if the urine is examined visually, it will be found to be clear or nearly so, but floating there will be seen stringy substance, which, if examined microscopically, is found to consist almost entirely of pus cells and is virtually what has been seen at the meatus, but now, owing to the weakened inflammatory action, pus is not produced in sufficient quantities to appear except by forcibly washing it out. How different the appearance, both visually and microscopically, when this débris is seen some three or four months' later. In the glass they (one or several) appear like pieces of white thread, and microscopically they are found to be composed of degenerated epithelial cells, pus cells, possibly a few cocci, all held firmly together in a mucus matrix, and being a positive indication of localized inflammatory action with new tissue formation.

The same condition may be present twelve to eighteen months after infection, and the canal reduced in caliber one to three numbers, yet detection by the bulb will not be evidenced sufficiently to say stricture exists except by finding the bloody string, soon to be described. Bloody, string-like clots must not be confounded with the true bloody shred or shreds, for with the former they may appear, following dilation of a healthy canal, where small meatus exists or injury has been done the membrane.

Visually, the first-named appear as blood, being string-like in appearance and consisting entirely of blood-cells, being held together in a hyaline matrix. On the other hand, the second, *i.e.*, those indicating new tissue formation, look like the true shred, but bloody in appearance, and if examined carefully are found to consist of exactly

the same material as the true shred, viz., pus, mucus, degenerated epithelium, with the addition of cells all held firmly together in a hyaline matrix. In a pathological contraction in the urethra the membrane behind contraction is not only dilated but chronically inflamed, and it is from this portion of the canal that we find the shred has its origin. These are not always formed longitudinally, as might be supposed, knowing that when at rest the canal is a closed tube, the membrane lying in folds, but, on the other hand, they may be and are often formed parallel to the circular muscles, lying in close proximity to the cicatricial contraction, which always encircles the canal. Although the major portion of the inflammatory exudate may be washed out by the urine and pre-instrumental flushing, soaking, so to speak, is necessary for its complete removal. As the instrument passes from before backward it is evident that the constriction will follow the same direction, but only to a certain degree, on account of its firm attachment to the surrounding tissues.

It is known that normal muscular tissue will stand dilation to a certain degree without laceration, but with chronically inflamed and infiltrated tissue the opposite occurs the moment stretching takes place above the caliber that exists. The blood and serum may exude either as the instrument passes in or is withdrawn, but one thing is positive, a certain amount, either by exudation from the newly-formed tissue or constricted apex, lands over the inflammatory area, where it infiltrates into the adherent débris, detaching the same and being washed out by the post-instrumental flushing. As the dilations are continued, the string or strings will become smaller in size, until they, with the true string, will entirely disappear. In using this procedure either for diagnosis or prognosis the fact must not be forgotten that, for the first, an instrument must be used of sufficient caliber to cause stretching of the constriction over that already existing, and, secondly, to be sure all new tissue has been absorbed, sounds must be used of a caliber that will stretch the circular muscles at least two numbers French over that which they normally assume.

As a positive evidence of the absorption of all new tissue formation, the following rule will hold good:

Dilation two sizes above the normal circular muscular caliber, at intervals of a week, for at least eight times, with absence of the bloody string at each séance.

With a rest of about two months, repeat the dilation, examining carefully for the bloody string. If not found, allow an interval of at least six months to elapse, when repeat the procedure as before: if none now appears, the same may be repeated once in six or eight

months for three or four times, when, if there is no reappearance, all new tissues may be said to have been completely and permanently absorbed.

In case where strictures are cut, the same general rule holds good.

Conclusions.

The stringy substance found in the urine during the early period of resolution (three to eight weeks) must not be confounded with the true shreds (three months and on), which are evidence of localized inflammation.

The bloody, clot-like string so often seen after dilation of the urethra, and due to contracted meatus, close navicular valve and the like, must not be confounded with the true bloody string, which consists of pus, degenerated epithelium, mucus and blood-cells imbedded in a hyaline matrix.

An antiseptic solution should always be used for flushing the canal previous to instrumentation, and following this an astringent should be used in the same way, this not only for allaying irritation but flushing out the evidences of new tissue formation.

For diagnostic purposes, the constriction must be stretched above that that already exists, and for prognosis at least two numbers above the normal circular caliber.

378 Franklin Street.

A CASE OF INITIAL LESION OF SYPHILIS AT THE HEEL.

By A. T. BÜCHLER, M.D.,
New York.

THOUGH the initial lesion of syphilis has been observed in almost every conceivable region of the surface of the human body, yet the case here reported, with its localization at the heel, is, as far as my reading goes, unique. The history of the case is, in brief, as follows:

On September 13th, 1901, W. L., a well-nourished female child, aged seventeen months, was brought to the Skin Clinic of the Dispensary of the Presbyterian Hospital for treatment of an obstinate lichen tropicus eruption, with which the child had been afflicted throughout almost the entire summer. The papules were scattered over the thorax, abdomen, and extremities, many of the lesions bearing on their apices excoriations from scratching. In addition to this very annoying

affection, there was present an oval lesion, extending transversely across the region of the right tendo Achillis, just above the heel. This lesion was distinctly elevated, well circumscribed, of considerable induration, and of dusky-brown color.

It presented a cup-shaped, central depression, covered by a yellowish-brown crust, the removal of which revealed a reddish, granular surface.

Its longer diameter measured about an inch; its shorter was about half that length.

The inguinal glands of the corresponding side of the body were considerably enlarged. Aside from the above-mentioned lichen tropicus eruption, the skin was absolutely normal, as were the mucous membranes, and, excepting the primary adenopathy, the lymphatic glands were not enlarged.

On inquiry, it was acertained that the patient was an only child, that she was perfectly healthy, at birth and since that time; that she had never been troubled with snuffles, and that she was entirely free from hereditary stigmata, a statement which was confirmed by examination. In regard to the lesion at the heel, this, it was stated, first appeared about two months ago as an elevation of the size of a small bean, and gradually increased until it reached its present dimensions. Concerning the mother, it was learned that she had never miscarried, that there was no history of genital lesions, but that for the last four months she had been the bearer of an eruption.

This, on examination, proved to be a papular syphilide at the hairy border of the forehead, of the abdomen, and thorax, in the stage of involution. Moreover, there were found large, fungating, offensive condylomata lata of the inguinal fold and inner surface of each thigh. There was a general adenopathy. The mucous membranes presented no changes. No traces of an initial lesion could be detected.

Reverting to the history of the child, her condition remained unchanged until September 30th, when she presented a well-marked papular eruption of the palms, a papulo-pustular syphilide of the forehead, and enlargement of the anterior and posterior cervical, as well as of the epitrochlear glands.

The subsequent history is of no particular interest; suffice it to say that during the next two months the child was affected with condylomata lata around the arms, the vulva and thighs, and with repeated outbreaks of mucous patches of the lips and of each angle of the mouth, which eventually responded to treatment, as did the initial lesion, which, at the time of writing (February 10th), is now indicated by a pigmented area of brownish color, with some infiltration. Granted

that the data furnished by the mother as to the acquisition of her own syphilis, and as to the course of the latter, are incomplete, yet the absence of all stigmata in the child, when first seen, together with the appearance of the lesion, so typical of the hard chancre, preclude the acceptation of hereditary transmission.

As it was customary for mother and child to sleep in the same bed, circumstantial evidence would point to the condylomata lata of the mother as the probable source of infection of the child, an excoriated lichen tropicus papule presumably serving as port of entry for the syphilitic germ.

Book Reviews.

Les Maladies Séborrhéiques. R. SABOURAUD. Paris: Masson et Cie., 120 Boul. St. Germain, 1901.

Sabouraud's work, which in its scattered form has become familiar and has excited not a little admiration, has, with the exception of the ringworm and impetigo essays, been collected with additions in this volume. It includes seborrhea (eczema seborrhoicum), acne and alopecia. All this vast group he holds is due to the activity of his microbacillus, alone or contaminated by other pyogenic organisms. His seborrhea includes everything, even the lichen annularis of his countrymen (certainly not the ringed lichen of other schools), as far as psoriasis; his acne, not only the ordinary variety but rosacea, acne keloid and acne necrotica; alopecia, the seborrheic sort and alopecia areata. There can be no reasonable question of his findings, but his interpretation of them needs toning down. Clinically, it is a matter of common knowledge that the scalp needs attention in all these disorders and bacteriologically it need excite no wonder that one organism is capable of causing such diversified ills when we remember that the blastomyces causes pus and tubercle formation and the streptococcus erysipelas, impetigo and furuncle. Moreover, it cannot be expected that complete proof in the form of production of all the lesions be adduced since no man can predicate the clinical type of any tuberculosis. At the same time why is it that this work cannot be duplicated in other lands? Why do not the brick red cultures appear in Scotland and America? Why does the organism remain quiet in certain sebaceous glands and not in others in one subject? It is not by any means to be found in every comedo. So far as is to be seen there is no effort to distinguish it from Welch's staphylococcus epidermidis albus, which is the most universal of skin flora. Unna's morococcus, very likely identical with Welch's organism, is cynically dismissed as "*légendaire*"; Malassez's is not mentioned at all. Sabouraud apparently does not know that Robinson long ago produced a patchy alopecia by injection of staphylococcus cultures. Until these and other points cease to be ignored, this verdict must remain "not proven." It may be that degrees of virulence alone are necessary to determine a pityriasis, an edema, or pus formation. If so, the demonstrations would be vastly interesting.

Sabouraud has undertaken to define seborrhea as a sebum flux, its etymological meaning, wherein he leaves a door wide to confusion. It is evidenced clinically by the greasy plug, filled with microbacilli which can be expressed from the follicular openings, a thing usually regarded as a normal condition, at least about the nose.

In their beginnings, at least, keloid acne and rosacea are not acneiform; "seborrheic" or senile wart is never microbic at any stage. As a corollary to the last proposition, since the verruca senilis is often precancerous, the microbacillus may be held to be potentially a cause of cancer. This seems a very general outcome to special lines of investigation, a too widespread generalization. The monograph is an interesting human document. J. C. J.

A System of Physiologic Therapeutics. Edited by Solomon Solis Cohen, M.D. Philadelphia; P. Blakiston's Son & Co., 1901. Vols. I to IV inclusive.

In opening this review, it is proper to say that circumstances over which the editors had no control have delayed its appearance and perhaps, in consequence, are responsible for to bring a noteworthy work to the attention of the Journal's readers. It is quite unique both in scope and character in American literature and is therefore really needed. The volumes present a most attractive appearance, the page is beautiful and illustration in color and black all that could be asked for. The contributors are well known for their labors in the fields the system is to cover and are not confined to America. Europe is drawn upon largely. The editorship could not have fallen into better hands, it is hardly necessary to remark. Dr. Solis Cohen may be trusted to see that the common faults of systems, overlapping and diametrically opposed contentions do not occur.

Vols. I. and II., edited by J. W. Jacoby of this city, are given up to Electrotherapy, the first volume containing the subjects, physics and apparatus, the second, methods and special application. Under the latter head there is an article by Ohmann-Dumesnil on electrotherapy of the skin which is admirable. Illustration is profuse. Of course, X-rays figure largely, but Finsen's method goes over to a later publication. Is it to be supposed that the editor regards electrotherapy as the first of the "methods other than drug-giving" that he presents it first?

Climatology fills the next pair and is considered by Parkes Weber of London, so there can be no suspicion of exploitation. It is claimed to be the first systematic treatise on the subject, and certainly it is in the sense that it is the most thorough. Limitations as well as qualifications are given to the end that the old happy-go-lucky fashion of sending a patient hither and yon may be replaced by definite notions of a place suited to his pocket and his individuality as well as his disease.

The publishers deserve every encouragement in their great enterprise. There are to be eleven volumes in all and the price of the set, which has been raised, is even now only $27.50.

Society Transactions.

FRENCH SOCIETY OF GENITO-URINARY SURGERY.

FIFTH SESSION.

(Annales des Mal. d. Org. Génito-Urin., 1901, p. 1327.)

(Continuation.)

Movable Kidney, Pathogenesis and Indications for Operation.—DR. E. CHEVALIER.

II. INDICATIONS FOR OPERATION.

Operations for movable kidney begin with Keppler (1879), but the surgical treatment of this affection begins really with Hahn (1881) who made the first nephrorrhapy. Nephrectomy, which was done by Keppler, has seemed to become more restricted in its indications in proportion as the auto-plastic operations have come to be practised.

A. OPERATIVE INDICATIONS ACCORDING TO THE FORM OF MOVABLE KIDNEY.—Often without symptoms, movable kidney may, however, make its presence known by three principal classes of symptoms: Pain, neuropathic and dyspeptic disturbances, often associated, but with such predominence of symptoms as to enable a classification under one of these three forms.

Movable kidney is simple when its symptoms are almost exclusively renal, it is then almost solely amenable to operative treatment; it is called complicated when other organs are affected (enteroptosis, splanchnoptosis), and, in this case is not ordinarily operated.

1st. DYSPEPTIC FORM OF MOVABLE KIDNEY.—Digestive disturbances are:

a. Mechanical (rare) intestinal obstruction, icterus, biliary lithiasis; and due to the compression exercised by the kidney; operation is here indicated.

b. Nervous (very frequent) atonic dyspepsia, dilatation of the stomach, constipation, &c., &c.

c. Due to enteroptosis. When this condition presents it would seem as if all surgical procedure should be discarded. There are, however, cases (Bazy) in which the nephroptosis playing an essential rôle in the genesis of this nephroptosic cachexia, operation is useful.

In general, however, the operative results of the dyspeptic form are mediocre; before intervention all orpthopedic and medical measures should be exhausted, and, moreover, should also be employed after such operation, when this has been resorted to.

2d. NEURASTHENIC FORM OF MOVABLE KIDNEY.—In this form, the worst from an operative standpoint, nephropexy furnishes half the unsuccessful cases.

It may occur in the nervous woman, in whom the genital apparatus should be well investigated in order not to ascribe to the kidney that which appertains to the uterus, or it may occur as well as in the neurasthenic or the hysterical. The role of nephroptosis may be important (Petrin and Bychowsky, Albarran) and nevertheless be unrecognized.

Nervous disturbances may antedate nephroptosis and be aggravated by it or they may be secondary to and follow nephroptosis. The operative results are as uncertain as in traumatic hysteria; they are sometimes injurious; in spite of the good results sometimes observed (Smith), operation should be resorted to only after orthopedic and medical measures have failed. We should use special circumspection in expressing ourselves as to possible results of operation.

3d. PAINFUL FORM OF MOVABLE KIDNEY.—This is the most satisfactory from an operative standpoint. Varying from simple discomfort to an onset of strangulation of the kidney and intermittent hydronephrosis, the pain is due in large measure to a crisis of retention. Nephropexy in these cases furnishes 80 per cent of cures. We must differentiate this condition from the other causes of neuralgia of the kidney, of the neighboring organs, of the general condition, and recognize the influence of fatigue, walking, repose and of reduction of the kidney.

Even in this form also the most simple means may succeed, massage and above all the orthopedic treatment. All are agreed in advising the latter means and in reserving nephropexy when it has failed. Albarran goes further and gives the patient the choice between nephropexy and wearing an apparatus; as one would for the radical cure of hernia.

Nephropexy is not grave; the mortality has been reduced to 3 per cent. and even to 1 per cent. But is movable kidney a grave condition? Schilling has found it is true albuminuria in 14 per cent; hematuria has been observed, but rarely; movable kidney is grave only from its complications of strangulation or hydronephrosis; the onset, above all the repeated onset, of these symptoms should call for operation. Aside from these indications it seems to the author preferable to operate only when orthopedic measures have failed.

4th. MOVABLE KIDNEY WITH COMPLICATIONS REFERABLE TO THE KIDNEY ITSELF. —Hematuria is cured by nephropexy (Guyon, Newmann, Israel, Albarran, Pasteau).

Tumors, lithiasis, &c., are treated irrespective of a movable kidney. Pyonephrosis in a measure furnishes the same indications as hydronephrosis, and in general lends itself to conservative operations.

B. OPERATIVE INDICATIONS IN HYDROPEPHROSIS WITH MOVABLE KIDNEY.

1st. SURGICAL INTERVENTION IN INTERMITTENT HYDRONEPHROSIS.—Landau (1881) does nephrostomy after four aspirations. Guyon (1889) cures his patients by nephropexy. Terrièr and Bandouin advise operation after subsidence of inflammatory symptoms. Bazy (1893) publishes the first antoplastic operation in France which Küster had already practised, Albarran advises ureteral catherization which Guyon and he recommend in 1897 and 1898 in showing the secretory value of the pouches of renal retention and the advantage of conservative operations. Pawlik, Kelly, Albarran, Tuffier, Michon and Pasteau recommend ureteral catherization preliminary to the autoplastic conservative operations of Küster, Bazy, Fenger.

2. URETERAL CATHERIZATION AS AN INDICATION IN THE TREATMENT OF MOVABLE KIDNEY.—In the treatment of intermittent hydronephrosis with movable kidney, the conditions are favorable for ureteral catherization, since there is no infection of the lower urinary passages. This catherization admits the possibility of making the diagnosis of retetion, of the condition of the ureter, of the secreting power of the kidney and also of its congener. It may suffice to cure some cases taken at the start (Schwartz and Imbert, Albarran, Michon and Pasteau,

Pawlik). During nephropexy it serves to mark the ureter more easily and to point out the indications for an autoplastic operation.

3. CHOICE OF OPERATION.—We should be able to dispense with ureteral catheterization and make our diagnosis by more simple means, phonendoscopy, palpation (Guyon, Glénard, Israël), inquiry into the crises, &c., which will permit the exclusion of cysts of the abdomen, affections of the liver, &c.

Save in case of absolute urgency (anuria), it is better to operate after subsidence of inflammatory reaction, rather than during a crisis.

The operation of choice is fixation of the kidney by the lumbar route whether it be nephropexy or nephrostomy with nephropexy. After having thoroughly explored the kidney, its hilum, the ureter, which may be catheterized by the natural route or by retrograde catheterization; the condition of the ureter will call for the following conservative operations:

a. Uretero lysorthosis (of Rafin), who cuts the bands holding the kinks of the ureter and reëstablishes its correct position.

b. Section of a ureteral spur (Fenger) simply or with suture of the two lips of the section respectively (Trendelenburg, Bardenheuer).

c. Uretero-pyelo-neostomy of Küster, the *pyelo-plicature* of Israël or the *capitonnage* of Albarran, if there remains a pelvic pouch then we can do a pyelo-ureteral anastomosis (Bardenheuer) with or without resection of the pouch (Albarran).

d. If the upper portion of the ureter cannot be freed, the *uretero-pyelo-neostomy* of Bazy, Küster, Bardenheuer should be done or ureterotomy, or lateral anastomosis (Helferich, Albarran).

These operations which are long and precise should only be performed after assuring ourselves of the general good condition of the patient, the condition of the opposite kidney and the integrity of the lower portion of the ureter. They should be performed after subsidence of inflammatory reaction and often as a secondary operation after recovery from a primary operation, above all if the hydronephrosis is infected.

Nephrostomy should be preferred if the lesion is far advanced or double, if it is believed that there is only one kidney or doubt about the other kidney, or if the general condition of the patient is below par.

Nephrectomy should be reserved for cases of long standing where the renal pouch has lost all secreting value and for those cases where the opposite kidney, being healthy, autoplastic operations are impracticable.

4. CONTRA-INDICATIONS IN OPERATION FOR MOVABLE KIDNEY.—These are the same as for any major operation. Albuminuria need not always be a contra-indication, for Menge (of Leipzig) has published cases of transitory albuminuria due to maneuvers of exploration and disappearing after repose. A cachectic state is not an absolute contra-indication (Bazy), nor a neurasthenic condition (case of Smith); but in a general way the dyspeptic and neurasthenic forms may be considered as contra-indications.

5. CONCLUSIONS.—Not one of the causes put forward to explain the pathogenesis of movable kidney suffices unless we count that of congenital predisposition and heredity.

Operative indications, exceptional in the dyspeptic and nerasthenic forms, give greater promise of success in the painful form, which should be operated upon after orthopedic treatment has proved unsuccessful.

Early operation should be performed in the cases accompanied by intermit-

tent hydronephrosis in order to avoid ultimately the necessity of a long autoplastic operation.

DR. PAUL DELAGENIÈRE.—The causes put forward to explain renal ectopy are in reality the predisposing causes.

The determining cause, perhaps essential, is strain.

Strain, it seems to him, alone can suffice in certain cases to produce displacement in individuals absolutely healthy, without ptosis, &c.

But if the distrophy, enteroptosis, &c., is present to enfeeble the means of fixity already insufficient of the kidney, the effort necessary to bring on displacement will be just so much diminished.

He insists, above all, upon pregnancy as a very important cause which can by itself exert a triple action.

It often brings on the distrophy; it provokes ptosis; it necessitates during parturition those violent efforts so much the more efficacious than those put forth in subjects predisposed.

For treatment nephrorrhaphy *en échelon* by the method of Professor Guyon has given at his hands only two unsuccessful cases out of twenty-two, and one of these two had a miscarriage some months after the nephrorrhaphy.

Pathogenesis.— DR. L. LANDAU.—Movable kidney is an acquired malady. There does not exist a single observation, anatomical or clinical, which can prove an origin which was congenital or an innate insufficiency of the means of holding the kidney.

Narrowness of the lower portion of the thoracic cage constitutes a predisposition.

These are the real causes:

A. CAUSES OF ANATOMICAL ORIGIN.

a. Rapid diminution of the adipose tissue a result of many maladies, febrile or apyretic.

b. Repeated and considerable modification of the intra-abdominal equilibrium.

From these causes results the diminution of the tension and elasticity of the abdominal walls of the skin, muscles and peritoneum. The abdominal muscles atrophy or become simply paretic and insufficient to hold the abdominal contents.

Hernial form, general enteroptosis, shows itself in *Venter pendulus.*

c. Inflammation and suppuration in the rectro-renal connective tissue, for example, in Pott's disease.

d. Scolosis and kyphoscoliosis.

e. Prolapse of the genital organs, prolapse of the uterus, prolapse of the vagina.

f. Primary maladies of the kidney; hydronephrosis, renal tumor.

B. CAUSES OF ORIGIN, PHYSIOLOGICAL OR MECHANICAL.

a. Exaggerated action of all the muscles of the abdominal cavity; great effort, excessive contraction, obstinate constipation, the lifting of heavy objects, whooping cough, &c.

b. Traumatic accidents.

Movable kidney is not then generally an essential malady, but is an acessory phenomenon occurring in the suite of other morbid states.

SYMPTOMS.

1. The symptoms in cases of movable kidney are very varied.

2. Movable kidney may cause disorders and accidents due to functional disturbances in the kidney itself. We may see:

a. Repeated congestions caused by circulatory disturbances in the kidney.

α Venous hyperemia; hematurias, very rare, it is true.

β The so-called strangulation by sudden torsion of the renal vein.

b. Hydronephrosis and pyonephrosis simple and intermittent, caused by kinking of the ureter.

TREATMENT.

1. It is necessary to take into consideration the maladies and morbid conditions accompanying movable kidney. Orthopedic treatment, massage, gymnastics, hydrotherapy, electricity.

He advises against the application of a bandage with a pad to the movable kidney itself; but rather an abdominal binder to the hypogastrium.

2. A nephropexy which transforms a kidney displaced though movable into a kidney displaced and fixed is generally useless and sometimes harmful.

3. It is only admissable when functional disturbances of the kidney exist and the usual therapy is insufficient.

4. The special treatment of hydronephroses and pyonephroses as well as of calculus, and pyelitis is the same whether the kidney is movable or not; mobility of the kidney facilitates as a matter of fact all surgical interventions.

DR. POUSSON has operated on but sixteen cases of movable kidney, though he has seen a large number. He has practically only interfered in those cases where the symptoms appeared to have direct relation with the nephroptosis. This is a point of pathogenic diagnostic importance from an operative point of view, and particularly delicate outside of these cases where there exist anatomical and functional alterations of the kidney, although in these same cases a cure is not always obtained after nephropexy, for, in certain predisposed cases, replacement of the kidney creates a neuropathic state which persists in simple reinstatement of the organ into its place and even becomes aggravated.

Of the sixteen cases operated upon by Dr. Pousson, eight presented the painful form, four the dyspeptic form, two the neurasthenic form; one had attacks of intermittent hydronephrosis; and one finally had profuse attacks of hematuria every time she maintained a standing posture for several hours.

None died from the operation, but two having had the kidney infected had to undergo nephrectomy. One of these patients had an attack of cystitis at the moment of operation, and the infection was of an ascending origin; in the other the infection took place directly upon the wound. In this latter case the patient had a displaced kidney, giving rise to profuse hematurias. Having incised it to discover the cause of the bleeding, he found at the level of the junction of the ureter with the pelvis a small valve obliterating the lumen in part and incised it. The kidney having bled abundantly, was tamponned and this tampon was the point of infection.

The fourteen other nephropexies were not followed by any operative complication. This new report adds to the statistics already published showing the comparatively slight gravity of intervention in nephropexy. As to the therapeutic result, nine of the cases only have been followed for a sufficient length of time to appreciate it. Four of the eight cases with the painful form have now remained cured for several years. The four others were lost sight of too soon. Three of the four with the dyspeptic form recovered from the nervous troubles of their digestive apparatus; only one of the two neurasthenics regained perfect health, but after presenting phenomena of post operative psychosis; lastly, the patient with intermittent hydronephrosis was definitely cured

Not having confidence in the employment of catgut to maintain the fixation, as he had been obliged to re-operate in one case in which he had used only absorbable sutures, Dr. Pousson always suspends the kidney to the last rib by a plain silk which serves for the other points of suture of catgut.

Being given the frequent cases of failure in the dyspeptic and neuropathic forms, Dr. Pousson asks whether it would not be expedient in the course of an operation in which attention should always be directed to the pedicle of the kidney, in order to verify the mode of union between ureter and pelvis, and the condition of the vessels, to take this time in the operation to exclude the nerves of the renal plexus and to influence the solar plexus *à distance*. The excellent results obtained by Dr. Jaboulay in severe neuralgias of the pelvis and other painful accompaniments of the abdominal viscera and even of the limbs by an intervention upon the sensitive fibers of the grand sympathetic open a new view in the therapy of the complex of renal ectopy.

Pyelo-Nephritis in Movable Kidney.—DR. ALBARRAN in 1895 first called attention to this frequent complication of movable kidney. He has been able to observe a large number of cases in which the renal infection developed without marked disturbance, scarcely more than a slight rise of temperature, some pain and with cloudy urine. At other times (four operations) the acute pyelonephritis gives rise to a general grave condition with fever showing marked oscillations and passing 40° C.

In these acute cases operation should be delayed because a nephrostomy not opening upon a collection of pus but indeed a kidney affected in its entire parenchyma would not offer much chance of success. It is better to institute a medical treatment (serums, diuretics, revulsives), which succeeded very well in the four cases treated, and to wait for the cessation of the crisis. When after twenty or thirty days the fever has disappeared, the reappearance of new attacks may be prevented by nephrorrhaphy; the operation made at this time is simple and gives excellent results.

DR. DURET.—When in 1888 he published his two cases of painful kidney in nephroptosis treated by nephropexy considerable incredulity was expressed as to the real efficacy of suture of the kidney and the permanency of the results. From the start he had recourse to experimentation; the very demonstrative results of which were given in the thesis of Dr. Vaneufville to the Faculty of Paris (1888). Since then other experiments by Tuffier and Albarran are confirmative.

He proposed now to establish: 1. That the anatomical process of fixation of the kidney in experimental nephropexies and in nephropexy in man give a definitive condition of fixation of the kidney if they have been well done.

2. That the remote clinical results of nephropexy are satisfactory if only the precise and justifiable indications are followed.

On the first point it is only necessary to refer to the experiments reported by Vaneufville.

In dogs whose kidneys are endowed naturally with a certain mobility he establishes after methodical nephropexy the fixity of the kidney which cannot be displaced in any sense because of the formation of a fibrous pedicle, which is implanted beneath the lumbar wall at the level of the incision, so resistant that on trying to detach the kidney an anatomical piece is torn iff with it, maybe a fibrous layer of one and one-half to two centimeters in thickness, formed by the posterior layer of the adipose capsule of the kidney and two or three conoid fibrous ligaments which attach the kidney to the vertebræ and last rib. An

anatomical examination made after a nephropexy shows according to a case cited by Dr. Duret that the same thing occurs in man. In a woman dying of tuberculosis five months after an operation of this kind, of which the observation is given in detail, a membraniform ligament was found, its dimensions being six centimeters in length by 2 cm. in thickness.

It extended to the superior pole of the organ, and was firmly adherent to the first, second and third lumbar vertebræ and the corresponding discs and to the twelfth rib.

Upon the second point, remote results of nephropexy, he reports very interesting results. He has only done a comparatively small number of nephropexies, about a dozen, because he has selected his cases: Complete nephroptoses in which the organ could be circumscribed by palpation, traumatic or otherwise, with or without intermittent hydronephrosis. He has avoided cases of general enteroptosis, corresponding to the descriptions of Glénard. In the few cases reported by him the cases have been seen three, five, seven, and twelve years after operation. Fixation of the kidney has persisted and the results have been complete from a functional standpoint. He draws the conclusion that nephropexy well done (by double puncture of the adipose capsule, and by ligature attached to the twelfth rib and traversing the capsule proper and a little of the parenchyma of the kidney) has given absolutely durable results.

Movable Kidney and Renal Neuralgia.—DR. DESNOS reported a case of a young woman twenty-five years old with movable kidney and extreme pain in the kidney region; with rest in bed there would be complete subsidence of the pain and a return of the kidney to its proper place. Nephropexy was performed April, 1899. The pains disappeared during the time she remained in bed the three weeks following the operation. After she was up they reappeared and gradually increased to such a degree that eight months after she returned and begged to have the kidney removed. Abdominal palpation showed a large mass felt through the abdominal wall, and he believed that he had a recurrence of mobilization to deal with together with twisting of the ureters and a production of hydronephrosis. Upon operation he found that the kidney was firmly fixed in its proper place, and the mass he had felt on examination was the liver which had descended and was movable. Taking into account the nature of the pains which were strictly renal and their violence he decided to remove the kidney nevertheless. After operation the pains had disappeared. There persisted a certain abdominal sensitiveness, but diffuse and of an entirely different character, which he believes explains the neuropathic phase of the malady.

Movable Kidney. Pathogenesis and Treatment. —PROFESSOR TEDENAT.— After discussing the question in which his views were largely in accordance with the preceding authors, he reports nine nephrorrhaphies on the right side: seven patients were perfectly cured, two continued to suffer and were obliged to wear the belt devised by Glénard.

Two cases of nephropexy on the left side for adhesions between kidney and colon, gave good results.

Movable and Painful Kidney in its Relation to Nephritic Colic.—DR. GALLAND-GLEIZE believes that from a sufficient number of cases observed in his practice he can draw the following conclusions.

1. The authors have not sufficiently insisted upon the frequency, much greater than is generally believed, of the painful crises which occur in the course of prolapses and movable kidney of which the physiognomy, the carriage and gait re-

semble singularly those of frank nephritic colic due to calculus, and which are, however, entirely independent of urinary lithiasis; these crises due to this condition are never accompanied by notable disturbances of urination; neither before, during nor following the attack, have blood, gravel or sand been found in the urine.

2. They do not appear to the author to have established with sufficient precision a distinction between the various conditions of pain which traverse, as an acute episode, the course of prolapses and movable kidney. They have had intermittent hydronephrosis too much in view. Now, the facts which he has observed have a physiognomy which distinguishes them sufficiently clearly from the attacks due to hydronephrosis.

In not one of his cases was he able to note marked true disturbances to the urinary function during an attack. There was neither anuria nor oliguria. On palpation the kidney never appeared increased in volume. In no case did he observe a great flow of urine following the disappearance of the tumor and the pain which is noted in acute intermittent hydronephrosis.

By all these characteristics, the painful accessions which he had noted distinguish themselves thus clearly from the crises due to hydronephrosis.

To sum up, it is by careful study into the antecedent history of the patient, a minute inquiry into the exact condition of the urinary function, a careful examination of the quality of the urine at the moment of the accession of the pain, after it and also during the interval, finally, it is by attentive and methodical exploration of the renal region that the physician will arive at a diagnosis exact and reasoned out from the occurrences found and eliminate all the causes of error.

What explanation, then, can be given for the painful crisis? He has none better to propose than that indicated by Tuffier and it is to that author that he turns.

As to the treatment which is applicable to them, there is no other except that, well understood, of the prolapsed kidney on the occurrence of which they made their appearance.

DR. CARLIER has operated upon eight cases only for movable kidney, though he has seen a large number. He does not believe that movable kidney is a stigma of degeneration, for it is impossible then to understand how it is that this malady attacks almost solely the feminine sex, and besides among such a large number of patients it is rare to find other signs of degeneration. As to himself, the influence of menstruation is undoubted; also we meet with movable kidney mostly during the epoch of genital activity. Movable kidney with painful symptoms are scarcely seen in old women because menstruation ceases to influence movable kidney. Dr. Carlier always employs catgut in his nephropexies, taking care to fix the kidney to the lose rib without disturbance to the pleura, through which the needle can be passed with impunity. It appears to him that the kidney unquestionably again becomes slightly mobile and this is fortunate; because the slight lengthening of the adhesions permits the kidney to be subject to the influence of respiration. Normally the kidney is slightly movable, and it seems to him entirely natural that after operation it should become slightly mobile as are all the abdominal organs.

DR. HÉRESCO has operated upon a woman 54 years old who had suffered for five or six years from renal pain. The crisis became more and more frequent, and the patient could practically no longer walk. Her urine was clear in spite

of frequency of urination. On palpation the lower pole of the right kidney could scarcely be felt. From the beginning the woman scarcely left her bed, where she lay stretched out, upon her right side, suffering frightfully and begging for an operation. A nephropexy was made April 16 of this year. Exposure of the kidney was easy, there was almost total disappearance of the adipose capsule. The pelvis was not distended. The kidney was fixed after Guyon's method. Operation succeeded. The speaker insisted upon the following points: (*a*) the pain disappeared immediately upon intervention; (*b*) the absence of distention of the pelvis makes us think that the pain may have been caused by the traction exercised upon the nervous plexus of the renal pedicle; (*c*) the advanced age (54) of the patient is a rare condition for nephroptosis. For explanation of this condition he cited the large number of deliveries this woman had had.

Movable Kidney with Displacement Behind the Stomach.—DR. P. HARMONIC.—Ordinarily the displaced kidney travels downward towards the pelvis.

More rarely it undergoes horizontal displacement and passes inward towards the vertebral column. In this latter case the characteristic clinical picture is on the one hand intensity of the painful phenomena, and on the other absence of urinary symptoms.

The horizontal displacement is never absolute, it coincides with a certain vertical displacement. But this latter occupies second place in the clinical picture.

Dr Harmonic publishes a case, 38 years old, extremely neurasthenic in whom in consequence of rapid emaciation due to an entero-colitis, the kidney was displaced in a horizontal direction.

The consequence was an atrocious pain, gastralgiform, occurring by crisis every time the patient attempted to lie on her left side. At the time of these periods, the patient would have an attack of vomiting with cold sweats and faintness. It only sufficed for her to turn on her right side for the crisis to disappear as if by magic. If she got up the pain diminished but less rapidly than under the preceding condition.

At the moment of the gastralgic attack, palpation would reveal the presence, in the median line, upon the vertebral column, below the xiphoid cartilage, of a hard elongated tumor, the size of an egg. It seemed like a neoplasm of the stomach.

It was simply the displaced kidney which slight pressure served to put back in position, and this maneuvre would stop the suffering. It is probable that the painful crisis was due to the compression of the solar plexus by the displaced organ.

Dr Harmonic performed a nephropexy, which was the only therapeutic resource. As a matter of fact a bandage, which in the beginning had sufficed to give relief while the displacement was exclusively vertical, had become entirely useless when the displacement took place behind the stomach.

In this case the operative difficulty consisted in bringing the kidney, which fell by its own weight toward the vertebral column, up into the wound. He was obliged to transfix the kidney by means of a long curved needle directed by the index finger.

Four silk ligatures traversed the kidney, and were knotted, after the technique of Terrier, upon the surface of the skin, after the wound had been

sutured. Each of these ligatures were removed two or three days after the second week.

The patient recovered completely and has continued in good health.

DR. LEGUEU considers movable kidney as the local and often the only manifestation of a general malady, bearing upon the fibrous, muscular and nervous tissues. This is often congenital in this sense, that the individual carries from birth the morbid predisposition.

The predominance so marked in the feminine sex should be sought in those conditions special to this sex, among which pregnancy, menstruation with its periodic congestions appear to him to play the most important rôle.

He has operated but little in movable kidney because he considers as concomitant and not as secondary the neurasthenic and dyspeptic phenomena which often accompany this condition. But he does not doubt that movable kidney in some cases reacts upon these symptoms to aggravate them.

From this cause comes the difference in the results obtained. One patient obtains complete relief, another gets only an illusory benefit from the operation.

He operates upon movable kidney with complications, also upon those simply painful; but he never operates for this reason alone, that there is movable kidney and dyspepsia or neurasthenia. When, however, at the same time that these symptoms are present there are also painful manifestations he has done the operation with excellent results, even as to the neurasthenia and dyspepsia. Under other circumstances he contents himself with prescribing a binder without a pad, as he has never seen a case where the pad maintained the kidney constantly and effectually in place.

Condition of Vascular Supply in Movable Kidney.—DR. PASTEAU.—There exists in renal ectopy and movable kidney a series of transitions ,which does not permit of their consideration as affections absolutely distinct.

We may divide movable kidneys, from the point of view of their displacement, into two grand classes, according as the kidney is displaced absolutely vertically, or as it descends more and more obliquely toward the median line until it becomes almost transverse in the umbilical region.

It is in the case of vertical descent that we meet the maximum lengthening of the vascular pedicle and this lengthening may be considered as congenital and primitive.

In the case of oblique movable kidney, the vessels are always less distended. It is well in this category to bear in mind the observation of luxation of the kidney, characterized by a sudden onset and painful phenomena due to congestion of the kidney from torsion of the pedicle.

DR. FRANZ GLÉNARD discussed movable kidney from the point of view that this malady in many cases is but an insignificant factor in the more important condition of enteroptosis.

DR. PAUL DELBET, after having followed several cases of movable kidney and read the greater portion of all that has been written, has arrived at the conviction that this malady is an affection almost always of uterine origin and that it is the consequence of an attenuated infection.

SECOND SÉANCE.

Treatment of Gonorrhea Complicated by Orchitis.—DR. BRIN has treated eleven cases of this kind, and contrary to the generally accepted opinion has practised immediate lavage of the urethra.

In one case only, the patient being very profoundly affected, was there a febrile rise the day following the first lavage, in consequence of which he interrupted the treatment.

In the other ten cases the success was marked. The testicle became painless from the second or third day. The swelling rapidly subsided, and so far from causing a relapse on the part of the testicle, the irrigations led to a cure of the testicular complication in the same time as the urethritis itself.

In order that the irrigations shall be without harm in these complications they should be made with but little pressure and with weak solutions.

There is no contra-indication to these irrigations except the condition of acuteness of the inflammatory lesions of the urethra, prostate and bladder.

Intensity of the testicular inflammation is not a contra-indication.

The advantages of this method are:

1. The gaining of time, the 10 or 15 days which the epididymitis lasts.

2. To induce rapidly the indolence of the testicle.

3. To permit the patient to quickly to work; several of his patients did not even go to bed even from the first day of treatment.

DR. ESCOT shared this opinion and made irrigations in every case complicated with orchitis or prostatitis, except during the acute period treatment called for antiphlogistic measures.

In twelve years' experience he had not seen a dozen cases of orchitis. He preferred, however, instillations of protargol to irrigation.

DR. BRIN feared instillations, which he thought were contra-indicated when orchitis appeared.

DR. GENOUVILLE had never seen orchitis in patients in whom he had used irrigations; at the most the testicle sometimes became slightly sensitive for one or two days, but nothing more. As to patients who came with orchitis, particularly when it was on the decline, he never hesitated to irrigate, and he was always pleased with the results; the pain quickly subsided and the resorption of the orchitis was very rapid.

Diagnosis and Therapy of Certain Chronic Urethritides.—DR. MOTZ.—The question of chronic urethritis is one of the most complex. The great number of theories of the pathogenesis and therapeutic indications clearly show the need of precise ideas. We must admit, however, that it is the lack of anatomo-pathological knowledge of urethral lesions which is one of the principal causes for all these opinions and hypotheses which are every day promulgated on chronic urethritis.

Thanks to the researches of Finger, Wassemann and Hallé we now possess the fullest description of the lesions of these conditions. These authors have shown that the lesions are diffuse and that they may penetrate far from the mucous surface and invade even the corpus cavernosum. The infiltrations are disseminated into the connective tissue and muscular stroma and ordinarily invade the glands found there. Pathological anatomy has shown us at the same time that we may have a complete cure of the mucous and submucous tissues by the formation of a sclerosis more or less pronounced although the inflammatory condition of the urethra persists. The foci of infiltration in these cases are found in the corpus spongiosum and are localized above all around the glands of the urethra, that is to say, they are situated far from the mucous surface.

Based upon the study of a large number of chronic urethrites, we may affirm that these adenties of the corpus spongiosum are the principal cause essential to the long duration and difficulty of cure of the great majority of cases of chronic

urethritis. These anatomo-pathological findings are in accord with the results of clinical observations which show us the tenacity of all varieties of adenitis.

It is then an absolute necessity in order to direct a successful therapeutic application of these urethrites to examine by every possible means, in order to discover the extent and depth of the urethral lesions.

Urethroscopy may in certain cases give us valuable information. But without entering into a discussion as to the importance of urethroscopy in general, it suffices to tsudy, from the point of view of the microscope, some chronically inflamed urethræ, in order to see that there are lesions either situated far from or separate from the surface by embryonic infiltrations of the mucosa, the existence of which cannot be established by a simple inspection of the mucous membrane.

Anatomo-pathological study, if it has not enabled us to remedy, has at least shown us the inefficiency of our diagnosis, and the depth and variety of urethral infiltrations.

The author began about two years ago to examine all cases of chronic urethritis by palpation that he could. This mode of examination, which has never, up to a certain point, been methodically employed by urologists, has permitted him in a certain number of cases to note the variety of the lesions and to form the prognosis and the therapeutic indications.

Direct palpation is insufficient to give any result; it should be made upon a rigid sound; the best is a Bénigué sound of large calibre. An attentive examination in this manner of normal urethral habituates the hand to note with just facility all infiltrations and nodosites which present for three-quarters of the circumference of the anterior urethra. These chronic infiltrations rebellious to treatment ordinarily present themselves for the most part in the form of round nodosites, hard, glandular or in the form of diffuse plaques. The localized rounded infiltrations may sometimes reach a considerable size, such that the patient himself may feel them by simple palpation and note their diminution or augmentation.

Unfortunately this examination cannot give complete information of the anterior urethra, for the superior portion beneath the corpus cavernosum cannot be perfectly palpated; still it can render good service when the lesions are not situated exclusively in the superior wall.

The establishing of the presence of these infiltrations is important for prognosis and therapeutics.

The prognosis of these cases is bad and it is our duty to so warn our patients.

As to therapy, we may be sure that above all in the case of nodosites, all lavage, instillations and cauterizations of the mucous membrane will accomplish nothing because the lesion is deep and often glandular.

We need not stop palliative treatment but should begin from the start with mechanical treatment.

This treatment consists in dilatation for at least ten minutes with large metallic sounds, followed by a massage of the urethral infiltration upon a Bénigué sound.

We should not deceive ourselves and think that it will suffice to make a few slight massages of these urethral infiltrations in order to obtain a rapid resolution of urethritis which may last years. The treatment demands a gift of patience on the part of both patient and physician. This treatment will give the

physician the conviction that he is following the shortest road which leads to a cure of his patient, because it is in accord with that now applied to all chronic infiltrations as in the prostate, peri urethritis, &c.

The results already obtained in a respectable number of cases in his private work as well as at the Hecker Hospital have convinced him absolutely of the utility and the necessity as well of urethral palpation, and he considers it his duty to examine in this manner all cases of chronic urethritis in his care. This method has permitted him to obtain rapid results in certain cases of urethritis with gonococci rebellious to classical treatment and has given him the satisfaction of being able to cure several patients, affected for years, with urethritis non-gonococci, which had been treated and abandoned as incurable by better urologists than himself.

DR. HENRY REYNÉ.—In searching the causes of chronic urethritis we should not only examine the urethra, but also the adnexa; by rectal touch and by urinary in several glasses we may ferret out with perfect precision the prostatic or vesicular lesions which keep up a urethritis. In several cases he has been able in five or six seances by massage of the prostate or vesicles to bring about a rapid cure. This mode of exploration well known to specialists is worthy of being received to all physicians.

Treatment of Gonorrheal Arthritis by Arthrotomy.—DR. PAUL DELBET.—Wasselin was the first to advise aspiration of articulations attacked by gonorrheal arthritis. Rendu employed aspiration followed by sublimate injections with success. The true surgical period begins in 1892 with Thierry, Walther, Fedmat, Spencer. However, and in spite of theses of Hopenkendler, Parizeau, Hoef, the method appears to have been extended but little. Forgues and Reclus only have recommended energetic intervention.

Intervention is perfectly rational, because it has been shown that gonorrheal rheumatism is only a joint infection. Two cases well marked are given. The first was a young patient with a tibia-tarsal arthritis whom he had treated medically; it took six months to cure and the case ended in anchylosis. In the second case, he treated by incision an arthritis of the knee joint. The patient was immediately relieved and was cured in five weeks with a mobile joint. He advised arthrotomy in all cases when the treatment by immobilization and revulsion does not bring about rapid relief, in pyarthritis, and very painful arthritis and arthritis with threatening anchylosis.

NEW YORK DERMATOLOGICAL SOCIETY.

300TH REGULAR MEETING, NOVEMBER 26, 1901.

J. M. WINFIELD, M.D., *President.*

Epithelioma of Cheek. Presented by DR. C. W. ALLEN.

The patient was a gentleman who had been treated by him with caustic paste and electrolysis, and subsequently with the X-rays. The last-mentioned treatment he proposed to continue for some months as a prophylactic measure. He thought the epithelioma had been cured two or three months ago, but as a precaution he had continued the treatment.

Dr. G. H. Fox said that he did not understand why Dr. Allen should use the paste, the X-rays and electrolysis all in the same case. A small epithelioma on the cheek or on the forehead could be thoroughly curetted under cocain without annoyance to the patient, and could be speedily cured in most instances. This was the shortest, pleasantest and, in his opinion, the most effective method of treatment. In an extensive case of lupus the curette would remove a large portion of the mass but would not prevent nodules springing up in the cicatricial tissue. By the use of a dental burr, however, one could destroy all of these nodules and set up enough inflammation to kill lupus or the epitheliomatous cells, and produce an absolute cure of the disease. The inflammation thus produced seemed to him similar to that caused by the paste. He had learned from experience that if the boring with the dental burr were done thoroughly in a case of lupus, however extensive, the case could be cured in less time than by the X-rays or the Finssen therapy. There were some cases of epithelioma so extensive that success could only be looked for from surgical operation.

Dr. George Thomas Jackson was surprised at the doctor's remark as to the use of the X-rays as a prophylactic. This was to him a new idea, and one which he had not seen mentioned in the literature of X-ray therapeutics.

Dr. Daniel Lewis said that he had had no experience with the X-rays in the treatment of cancer, but last summer he had seen Mr. Clark's case in the Middlesex Hospital. That patient, a woman of about seventy, had a cancer covering the entire site of the right mammary gland, and involving the skin chiefly. It presented a rough, nodulated, ulcerated surface. She had been treated daily since last March by exposure of about fifteen minutes to the X-ray. The photographs showed that the ulceration of the cancerous tissue had been reduced nearly one-half, but no progress had been made beyond this point during the last two months. This was in accord with his own experience with other agents. For example, a few years ago pyoktanin had been found to produce good results up to a certain point, but beyond this one could not go. In the case under discussion it seemed to him that the best thing to do with the central nodule was to remove it with Keyes' cutaneous punch. This instrument he had improved by having it made with a longer handle. He did not now use caustics as frequently as he did ten years ago.

Dr. P. A. Morrow said that as the X-rays might be considered as yet on trial, and their value somewhat *sub judice*, he thought it would be better to use that treatment exclusively in these cases. Something was known of the value of curetting followed or not by caustics; also just what could be accomplished by caustics alone. Where other treatments were employed in conjunction with X-rays, as in the case reported by Dr. Allen, it was very difficult to determine the precise measure of therapeutic value to be attached to the X-rays. The speaker said that he had a number of times removed small epitheliomata which were sufficiently circumscribed to be brought within the circle of the cutaneous punch, and in perhaps half a dozen cases he had, with a slightly larger punch, taken a portion of healthy skin and transplanted it. The union had been perfect in each one of these cases, and there had been no contraction. In one case, which he had submitted to the American Dermatological Association years ago, the line of union of this circle of transplanted skin could not be discerned by the naked eye, though it could be made out under a magnifying-glass. Of course, in such cases he made a section deep enough to take in the entire thickness of the true skin. It was astonishing with what rapidity union would occur.

DR. J. A. FORDYCE said that it was superfluous to treat these small circumscribed epitheliomata of the face by means of the X-ray; the use of the curette seemed to be sufficient, though he preferred to follow the curette with the application of the Paquelin cautery or of the caustic paste. He had seen several recurrences take place and the disease decidedly aggravated by curetting without the subsequent use of caustics.

DR. MORROW said that yesterday he had had at the New York Hospital a case of epithelioma of the root of the nose, which illustrated what Dr. Fordyce had just said. The patient had been treated several different times simply by curetting the surface. She had returned with a recurrence. He had finally curetted and then applied chloride of zinc. This had been done three years ago and the result was a perfect scar with absolutely no evidence of recurrence. The patient had returned because of another epithelioma located at the hairy scalp some three or four inches distant. It had always been his practice to use either the cautery or some chemical caustic, preferably the chloride of zinc, after the curetting. In this way deep-lying cells could be destroyed that would otherwise probably lead to a redevelopment.

DR. FORDYCE recalled the case of a woman who, three years ago had had curetted a small epithelioma at the wing of the nose. She had not returned for some time, and when she had done so there was an enormous epithelioma of the nose, and the new growth was the size of a hen's egg. She had had numerous hemorrhages, and he believed was now dead. This little growth had taken on a new growth after curetting, and this might not have occurred if caustics had been used.

DR. LEWIS said he wished Dr. Morrow or Dr. Fox would explain the advantage of first curetting and then using an escharotic such as the actual cautery. Personally, he could see no logic in such treatment.

DR. MORROW said that sometimes epitheliomata were so situated that, for cosmetic considerations, if for no other, one did not desire to remove too much tissue. If an incision were made sufficiently wide to go beyond all possible infiltration, or if the curette were used to the same extent, there would be no indication for the subsequent employment of the cautery, but in many cases one did not destroy the tissues so widely. He was of the opinion that these chemical caustics have more or less of a selective action, and will destroy cancerous tissue more rapidly than healthy tissue, and that in this way one could get a maximum result from a minimum loss of tissue. Moreover, a large mass of tissue could be removed painlessly with the curette followed by the caustic, whereas it could not be done with the caustic alone except by a painful and tedious process. He had tried the dental burr, but had found that the patient complained a good deal of the pain.

DR. FOX said that it was certainly true that the curetting process was quick, almost painless and efficient. The return of a small epithelioma after curetting was usually because the curetting had been superficially done. Even with the most thorough curetting lupus and epithelioma were apt to return because of small prolongations going down into the tissue beyond the reach of an ordinary curette. After curetting, these prolongations were exposed and could be reached by a fine Paquelin cautery, which will also destroy healthy tissue, or by chemical caustics which have a selective action or by the dental burr which is preferable. He had recommended the use of the burr in the treatment of lupus many years ago, and now, after years of experience with it, he would not think of using

either a caustic paste or the Paquelin cautery. The dentist does not, in treating a carious cavity in a tooth, cut out a solid block of dentine, but, guided by the sense of touch, pushes the burr in all directions in which diseased tissue lies. One can operate in the same manner upon the skin and just as well blind-folded as with the eyes open. The burr reaches all the morbid tissue, which is softer than the healthy skin, and it effects a permanent cure. He wished others would try the burr and compare their results by this method with those obtained from other methods.

DR. ALLEN said that the X-rays were not supposed to act as a chemical caustic, indeed, it should be used in such a way as to avoid the production of a dermatitis. He thought many of those who had spoken had lost sight of one important point. The moment a burr or curette is used one does a cutting operation, and there is danger of leaving behind a certain amount of invisible diseased tissue besides opening up channels for possible dissemination. The caustic paste seemed to follow out this diseased tissue even where the eye could not go. There were clinical data to substantiate this view. We knew that after cutting operations recurrences are to be expected.

Epithelioma of Finger.—Presented by DR. ALLEN.

DR. ALLEN said that to illustrate his views on this subject he would present another case, that of a gentleman sent to him by a physician in Chicago, Dr. Pusey. Since birth the gentleman had had upon his ring finger a pigmented mole. He had always worn a ring to hide this mole. The ring had often caused irritation, especially for the past two years. In July last, ulceration and tumor formation had begun at the site of this irritation. A diagnosis of sarcoma had been made by a very competent physician, but this diagnosis had not been confirmed by a microscopist. The growth had been excised at Hot Springs. Two months ago the growth had recurred in the form of a series of wart-like pearly nodules extending deeply into the tissues with surrounding induration. A little over one month ago the lymph nodes of the axilla had begun to enlarge, but had not been tender. A portion of the growth had just been excised for microscopical examination. He proposed to treat the case by the X-rays, possibly after the use of caustic paste and excision of the nodules. After an application of the paste he employed the X-rays in the hope that they would seek out and destroy the last vestiges of disease. If the X-rays would do this we had a new and important means of treatment. If one were likely to get recurrence after cutting, why should not recurrence follow curetting? His own method was to use the curette lightly, simply to scrape off the loose tissue and prepare the field for the use of the paste. He did not feel that this does any harm because new channels for possible infection and dissemination of the disease are not thus opened up.

DR. FORDYCE advised excision of the axillary lymph nodes, and DRS. H. H. WHITEHOUSE and G. T. JACKSON concurred in this opinion.

DR. JAMES F. JELKS, of Hot Springs, Ark., present by invitation, said that this man had been sent to him from Chicago by Dr. Pusey and he had diagnosed epithelioma and had removed it by excision. He had dressed the case for a few days, and then the man had not returned. Evidently recurrence had taken place in the scar, and he thought nothing could be done except in the way of surgical procedure. He would favor removing the whole finger and then taking out the lymph nodes under the arm, following up the chain of lymph nodes. He saw no other hope for the young man.

DR. C. W. ALLEN said that this was practically what he had proposed to do, not thinking it justifiable to experiment on this case with the X-rays. He expected to apply the X-rays to an obscure condition of the abdomen in an old gentleman. The person was too old for operation, and the condition was suspected to be malignant. Dr. Allen said that fourteen years ago he had removed a woman's breast for carcinoma, with the assistance of Dr. Daniel Lewis, and had cleaned out the axilla thoroughly, and the patient was alive to-day without any sign of recurrence.

Two Cases of Favus of the Nails.—Presented by DR. C. W. ALLEN.

The patients were two young women. The first was a lady of twenty years, whose right index finger had been affected for three years, and that of the middle finger for several months. The other nails were healthy and perfect with the exception of the fourth on the left hand. Here the disease appeared to be commencing on the attached posterior border. If this were an example of autoinfection on this unusual portion of the nail, it had probably occurred through the use of a manicure instrument. The mother had had a similar lesion on the left hand, and it had lasted for sixteen years. The sister said that at the age of sixteen she had also had this same affection, involving the fourth finger on one hand and the third on the other hand, and that it had lasted for a number of years. Neither the mother nor the daughter had had any treatment, and the patient here presented had not had any treatment up to about four months before coming to him. In the middle nail the disease had passed beyond the lunula. The microscope showed mycelium and strings of large ovoid spores with bright centres.

The second patient was a lady of twenty-five years, in whom the disease had existed since the age of five years. She had had occasional treatment, but the disease had never been cured. In this case the microscope showed branching mycelia but no outlying spores. He had only seen the patient yesterday, and it was possible that the case was one of ringworm.

DR. E. B. BRONSON thought it unusual that the disease should begin at the proximal end of the nails.

DR. FORDYCE thought that in the early stages of favus of the nails the diagnosis could be made, but ordinarily it was difficult or impossible to differentiate ringworm, psoriasis, favus and eczema of the nails.

DR. ALLEN said that he had occasionally seen favus of the nails where there had been favus of the scalp. It was quite remarkable that several members of one family should have favus of the nails and recover without treatment.

Ringworm of Face and Chest.—Presented by DR. O. H. HOLDER.

The patient was a girl who had come to the New York University for treatment. She presented a number of circinate lesions on the face and body. He presented her as a case in which the ringworm fungus had caused an unusual number of lesions. Two other members of the family had developed ringworm. According to the history, this girl had been accustomed to hold against her face a kitten having some skin disease. The affection in this girl was only ten days old now. There were also numerous lesions upon the chest.

DR. MORROW remarked that it was the most precocious development of ringworm, so far as the multiplicity of lesions was concerned, that he had seen. Climate seemed to have a wonderful effect in developing a luxuriant character of growth. He had seen in Mexico and in Honolulu most remarkable and rapid developments of ringworm on the body. These abundant fungous growths were

very much like the extraordinarily luxuriant growths of plants in these parts of the world.

DR. ALLEN said that he had occasionally seen rather rapid dissemination of ringworm of this nature. He recalled the case of a lady who had come to him about fifteen years ago with rings all over the chest. Inquiry showed that she had a pet cat with some skin affection, and inspection showed the same disease in the cat.

DR. O. H. HOLDER said that under the microscope the case presented a very slender mycelium with external spore formation, but no clusters of spores.

Folliculitis Decalvans. —Presented by DR. GEORGE THOMAS JACKSON.

This was the patient who had been shown to the Society last March. He had been under his observation constantly ever since. At intervals a new crop of pustules would appear, and the hair would fall out. The whole scalp was now affected in patches.

Epithelioma and Lupus. —Presented by DR. C. W. ALLEN.

This patient, Mrs. M——, fifty-two years of age, had come to him in April, 1901, with an epithelioma involving almost one-half of the forehead. The patient was still under treatment, but the epithelioma element seemed to have been cured. There was also a lupus, which had begun twenty-four years ago. The lupus had been operated upon by Drs. Fox, Jackson and Ransom. He had treated the patient first with caustic paste, and then with arsenical solutions, but later by electrolysis and the X-rays.

A Case of Lupus Erythematosus. —Presented by DR. H. H. WHITEHOUSE.

The patient was a man who had had the disease for eleven years. It had begun on the right cheek and had gradually extended to the scalp. The case was presented not so much because of its clinical appearances, but to bring out the question of treatment. The man had had all sorts of treatment, but wished now to submit himself to the action of the Roentgen rays.

DR. FOX said that his experience in curetting lupus erythematosus had not been very favorable. It was far more difficult to curette than lupus vulgaris. He would suggest that a good photograph be taken before beginning treatment with the X-rays, and then at various stages of the treatment, in order that a proper estimate of the value of the treatment might be made.

DR. E. B. BRONSON said that experience was opposed to the use of severe escharotics in lupus erythematosus. The strongest caustic that he uses in such cases is carbolic acid, and this sometimes seemed to do some good. As a rule, the more irritation the more the disease spreads.

DR. ALLEN was of the opinion that curetting constitutes the best possible treatment for lupus erythematosus. He had never seen the irritation referred to, and had been very much pleased with the results of curetting. The operation was not especially painful, and the tissue underneath the surface is rather soft. He often does nothing but curetting, though he prefers in the intervals to make free use of the calamine lotion.

DR. CHARLES T. DADE said that the experience at the Vanderbilt Clinic seemed to bear out what Dr. Bronson had said. Last spring a boy had come there with a new spot near the ear. It was curetted very thoroughly, and this spot had spread much more rapidly than the other portions. He would not care to use the curette again except where the disease is specially virulent.

DR. J. M. WINFIELD said that he had recently seen a case of lupus erythematosus that had been treated for eight months by the X-rays, receiving two or three

sittings a week. Apparently it had not been in the least benefited. He had then looked up the literature and had found that the results had not been very good, certainly not nearly so good as in lupus vulgaris.

DR. MORROW said that Mr. Morris, who had had an exceptionally large experience in the treatment of lupus erythematosus, had stated that he did not regard the X-rays as well adapted to the treatment of this affection.

DR. WHITEHOUSE said he agreed with Drs. Bronson and Dade that the milder the treatment the better the results. It should not be forgotten that many of these cases get well spontaneously. He had had three cases which had apparently recovered under the internal use of one grain of iodoform, three times daily.

Selections.

CUTANEOUS DISEASES.

On a Family Form of Recurring Epistaxis, Associated with Multiple Telangiectases of the Skin and Mucous Membrane.—WILLIAM OSLER (*Johns Hopkins Hospital Bulletin*, Vol. 12, No. 128, Nov., 1901, p. 333).

In the three cases described by the author, two belonged to a family in which epistaxis had occurred in seven members. Both of the patients had had bleeding at the nose from childhood, and both presented numerous punctiform angiomata on the skin of the face and of the mucous membrane of the nose, lips, cheeks and tongue.

The third patient had suffered in an usual degree from recurring epistaxis and the telangiectases were most abundant over the body and very numerous also on the mucous membrane. The condition has nothing to do with hemophilia, with which the cases had been confounded. This patient contrived a very ingenious arrangement to stop epistaxis. He took a rubber finger-stall about three inches long, into which was tied a small bit of rubber tubing with a stop-cock at one end. He inserted the finger-stall, relaxed, then put the tubing in his mouth, inflated it, and turned the stop-cock. He left it in for fifteen or twenty-five minutes and it stopped the bleeding entirely.

Angiomata have a curious relationship with affections of the liver. In cirrhosis, in cancer, in chronic jaundice from gallstones spider angiomata may appear on the face and other parts. They may be of ordinary stellate variety, like the stars of Verheyen on the surface of kidneys, or the entire area of the star may become diffusely vascularized so that there is a circular or ovoid territory of skin looking pink or purple, owing to small dilated venules. A dozen or more of these may appear on the trunk, or even large ones may disappear.

In a few cases of disease of the liver, the writer has seen large, mat-like telangiectases, or angiomata involving an inch or two of the skin, and looking like a very light birth-mark but which had appeared during the illness. The skin was not uniformly occupied with the blood vessels, but they were abundant enough on the deeper layers apparently to give a deep change in color and to form very striking objects. The dilated venules on the nose, and the chaplet

of dilated veins along the attachment of the diaphragm are not infrequently accompaniments of the spider angiomata in cases of disease of the liver. The writer saw the spider angiomata appear in the face in a case of catarrhal jaundice.

A Case of Dermatitis Gangrænosa.— T. M. FINNY (*The Dublin Journal of Med. Sci.*, 1901, p. 401).

Boy aged two and three-quarter years, when first seen was suffering from pustules of small size, not larger than a large pin-head, situated in the suprapubic region, on the skin of the penis, and prepuce, wrists and backs of hands. In three weeks' time these pustules were converted into deep and wide ulcers, rounded base covered with pus—at the same time the destructive process was similarly progressing in the eyelids and cornea, a veritable panophthalmitis. There were no bullæ present at any time. There was no evidence to associate the eruption with either vaccination or varicella. The ulcers did not seem to be very painful or very irritable. The lower limbs were covered with an ill-defined rash, not unlike that of measles. The lips and margin of the alæ nasi were also sore and ulcerated. The child was greatly emaciated and had a cough; no physical sign of lung disease were discoverable. The post-mortem examination revealed general tuberculosis. The thymus gland was caseating; a caseous nodule existed in the apex of the right lung and similar patches through the left; the bronchial and mesenteric glands were caseous. The tonsils were ulcerated and the cervical glands enlarged and firm.

Cases of Purpura, Ending Fatally, Associated with Hemorrhage into the Suprarenal Capsules —E. GRAHAM LITTLE (*The British Journal of Dermatology*. Vol. 13, 1901, p. 445).

The cases reported by the writer are divided in three groups: Eleven cases of hemorrhage, into both suprarenal capsules, proving rapidly fatal, in which purpura was noted before death. In those cases, the following symptoms prevailed, which, according to the author's views, form a natural clinical group; a young child, usually in the later period of infancy, is apparently in normal health. He wakes up one night and is a little sick; he lies restlessly till morning, passes a loose motion or two and suddenly develops a purpuric eruption and becomes alarmingly ill. He is dead in twenty-four hours and there is no pathological feature of importance to be detected at the autopsy except gross hemorrhage into the suprarentl capsules.

(2) Two cases of hemorrhage into both suprarenals not associated with purpura, though the other clinical features and the pathological appearances bear a strong likeness to those described in the cases of the first group.

(3) Four cases of hemorrhage into one suprarenal body, proving more or less rapidly fatal, but not so rapidly as in the first group, and not associated with purpura.

The Histology of Soft Nævi.—G. JUDALWITSCH (Blaschko Poliklinik) (*Archiv f. Der. u. Syph.*, Vol. 58, 1901, p. 15).

In a very exhaustive article with appropriate clear drawings, the writer undertakes to solve two questions:

(1) Whether the nævus-cells are developed from epithelial or connective tissue cells, and (2) whether the connective tissue bundles originate from the connective tissue of the cutis, or from the nævus-cells themselves.

The nævus of a twenty-six year old patient, from the region of mons veneris,

existing since childhood and gradually growing, served him for the purpose of histological examination, with the following results:

(1) The cells originate from epithelial cells, and (2) the cells of the nævus form bundles of collagenous and elastic tissue, in other words, the epithelial cells change into connective tissue cells. During this transformation the epithelial cells undergo the following changes: Hyperplasia and pigmentation.

(2) Hypertrophy of the cells, followed by shrinkage of the protoplasm owing to the loss of the epithelial prickles.

(3) A shaving off of separate epithelial cells and deposition of same in the cutis.

(4) A gradual depigmentation and condensation of the protoplasm.

(5) Formation of polygonal nævus-cells with vesicular nuclei.

(6) New formation of connective and elastic bundles.

(7) Permanence of cells with vesicular nuclei lodged in the connective tissue bundles.

There is very seldom a chance to observe all the aforesaid stages of development of the cells of the nævus from the epithelial cells, as the growth of the nævi is repressed and checked very early and they are rarely examined in the earlier stages of their development.

In non-pigmentary nævi this observation is still of greater rarity, as the growth of the non-pigmentary nævi is arrested even earlier.

Regarding the new formation and spreading of the connective and elastic tissue bundles, they can be observed in any nævus, provided the examined nævus is in the stage of depigmentation. He accepts Kromayer's opinion that metaplasia takes place, the epithelial cells being changed into connective tissue cells.

The pigment cells play an important rôle in the formation of the nævus. Simultaneously with the appearance of the pigment, the hyperplasia of the epithelial cells takes place and only with the full formation of the nævus, the pigment disappears and the greater changes in the epithelial cells coincide with the presence of the largest amount of pigment; thus the metaplasia of the epithelial cells and the pigmentation are at their height simultaneously and when the change is complete a depigmentation of the cells takes place. [There is no adducable evidence of metaplasia between epithelium and connective tissue cells. Adult nævi, moreover, are not fit subjects for the study of histogenesis.—Ed.]

A Peculiar Affliction of the Skin of the Nose in Children (Granulosis rubra nasi).—T. JADASSOHN (*Arch. f. Derm. u. Syph.*, Vol. 53, 1901, p. 145).

The first case came under the author's observation in 1890, and since that time six cases more fell under his notice. The clinical aspect of the disease is as follows: On the tip of the nose and the nasal ala a pronounced and sharply defined redness, easily disappearing under pressure is to be seen; upon this basis single papules of dark-red color are scattered. The papules are often very small, the size of the point of a pin and hardly raised above the surface; sometimes they are of a pin-head size and rather prominent; they are rather conical than flat, not arranged and not clustered. It is clinically impossible to determine whether they are localized in the opening of the sebaceous or sweat glands. They do not pale under pressure (no yellow brownish discoloration). There is no infiltration. Sometimes the papules will change into pustules, which quickly dry up. The skin of the nose is cold, telangiectesia is very little pronounced, sometimes entirely absent. No scaling and no scarring; only once

a very slight atrophy of the skin of the tip of nose has been observed. In some cases a slight hyperidrosis of varying intensity either of the nasal skin or the whole face could be seen. The course of the disease was a uniform one although the symptoms varied slightly; the redness was more or less pronounced; in one case being entirely absent, the papules developing upon quite normal skin. The papules themselves occur in large or in small numbers, and may be hardly noticeable. The localization upon the fleshy portion of the nose was always a feature. All his patients were children, six girls and one boy of between seven and sixteen years of age. The disease appears very early and lasts many years. The children were mostly of feeble constitution, but rather a hereditary, not personal, history of tuberculosis could be brought out. Injections of tuberculin failed to produce a reaction. The writer excludes lupus vulgaris and erythematosus, acne rosacea, hidocystoma, dysidrosis and tumors and is obliged to consider it as a "morbus novus nasi."

For histological examinations he obtained material from four cases and arrives at the conclusion that we have here to do with a chronic inflammatory process, which seems to start in the vessels, especially about the ducts of the sweat glands. The pus cells play a very insignificant rôle in this chronic inflammatory process, although they are met with when the process is in its acute stage.

The degenerative changes in the infiltration-cells are only slight—they never reach the stage of caseation. The very rare cells here are of no account. The disease is also histologically different from acne, lupus erythematosus and tuberculosis. The writer did not make inoculations, but he reports that Luithlen failed in his case with inoculations. Neither clinical observation nor histological investigation has thrown any light upon the question of the etiology of the disease. Up to the present time, the writer has not seen any cure in the cases, but it seems that the process has a tendency to disappear with time. He applied sulphur, resorcin, ichthyol, and many other applications used formalin in high percentage and cauterization, all with no beneficial results.

In an appendix, the writer considers the possibility of Luithlen's case (Kaposi's Festschrift, 1900, p. 709), being of the same category but in a more developed condition.

Five Cases of Nævi Cystepitheliomatosi Disseminati (Hidradenomes Jacquet, Darier, etc.)—A. GASSMAN (Jadassohn's Clinic). (*Arch. f. Derm. u. Syph.*, Vol. 58, 1901, p. 177).

The writer thinks he is entitled to the conclusion that the aforesaid tumors are of epithelial origin, as he was fortunate enough to produce a picture of a microscopic preparation where the direct connection between a cyst and epithelia by means of a cellular column is unquestionably demonstrated. Such a picture can be regarded as one of the greatest rarities, as out of one thousand serial sections examined by the writer, only in one, the aforesaid picture could be seen.

A critical review of the literature of the cases is included in the article.

The Etiology of Alopecia.—By DELOS L. PARKER (*Medical Record*, LX, 1901, p. 45).

According to the opinion of the writer alopecia is caused by a poisonous material (trichotoxicon) absorbed by the blood from the air-cells of the lungs, where it has been elaborated by the decomposition of the organic material nor-

mally present in respired airs. In some individuals, whose breathing is of the superior costal type, respired air remains undisturbed in the upper portions of their lungs. The respired air contains organic material, which in the presence of warmth and moisture of the lung cavity undergoes decomposition, and a product is elaborated which being taken up by the blood exerts a selective poisonous action upon the growth of the hair and becomes the cause of alopecia.

In support of this theory the writer brings forth a statement that "A personal observation extending over a period of ten years and applied to thousands of cases, has never failed to give him ocular proof of the existence or non-existence of superior costal breathing, according as the individual under observation was or was not free from the form of alopecia under consideration."

To prove the correctness of this theory the writer made the following experiments upon animals. The respired air of a middle-aged man who had suffered from alopecia, was kept in warm and moist surroundings long enough for decomposition of its organic matter, and the substance resulting from this decomposition was injected into a medium-sized fox terrier dog and a large hen. After fourteen injections have been made a strip of bare skin about the size of the middle finger had appeared along the center of the posterior part of the abdomen of the dog, and one the size of the whole hand over the same part of the hen. After fifty-two injections the whole abdomen of each animal was bare, and irregular areas of uncovered skin extended upon the sides. These were symmetrically placed upon the two sides of the same animal.

In order to meet the objection that respired air from a man not suffering from alopecia and atmospheric air can produce the same effect, experiments were made with liquid which contained respired air (1) from a man without alopecia, (2) from a man with alopecia, with a liquid which contained (3) atmospheric air, (4) freshly respired air where no decomposition had occurred, and (5) distilled water. Only the pigeons treated with Nos. 1 and 2 showed patches upon the abdomen that were bare. The other pigeons treated with 3, 4 and 5 were unaffected.

A Case of a Primary Tubercular Ulcer of the Penis.—(Pospelow's Clinic.—M. A. TSCHLENOFF (*Archiv f. Derm. u. Syph.*, LV, 1901, p. 25).

According to the writer there is recorded only one case of a primary tubercular ulcer of the skin of an adult. This case, which occurred in the private practise of Prof. Prospelow, is the second one published.

The patient, 43 years old, was affected with an ulcer upon the glans and sulcus rectro-glandularis of the penis, surrounded by an elevated, hard, irregular border, having in some places a punched-out appearance. The worm-eaten floor was covered with a tenacious, muco-puriform secretion; no miliary tubercles were noticed, no pain. Neither the lymphatic vessels nor the glands were swollen; and the skin did not exhibit any lesions.

Microscopical examination gave a classical picture of a tubercle. Only very few tubercle bacilli were found in the sections. No animal inoculation was undertaken.

The statements of the patient did not raise any suspicion of the existence of tuberculosis in his family. A thorough examination of the patient and his wife did not reveal any signs of tuberculosis or scrophulosis.

Alopecia Areata; a Clinical and Experimental Study.—By NORMAN WALKER and MARION MARSHALL ROCKWELL (*The Scottish Med. and Surg. Jour.*, IX, 1901, p. 12).

The authors carefully examined sixty-three cases of alopecia and made cultivations from a large number of the cases in order to determine either the parasitic or neurotic origin of the disease. The hairs from each case were examined microscopically. They were stained with Morris' modification of Gram's method, and organisms were found upon them; some of the hairs being sheathed with bacteria almost as closely as are the hairs in ringworm with fungus. In a large proportion of the cases seborrhea was observed.

The inoculated hairs gave a glistening white growth and the organism was apparently the s. epidermidis albus of Welch.

In two cases portions of the skin were excised and examined histologically. In both cases the organisms were found in the follicles and slight inflammatory changes in the epidermis and around the vessels were found. No organisms were found in the lymph spaces of the corium.

Several histories are given showing the occurrence of direct contagion. A table containing notes, concerning the duration, the extent of the disease, the contagion, the presence or absence of a history of ringworm and the presence or absence of nerve symptoms, is given to illustrate the point taken by the authors that the nervous element in this disease has been greatly overrated.

GENITO-URINARY DISEASES.

Clinical Report of a Second Series of Twelve Cases Benefited by Bottini's Prostotomy.— RAMON GUITERAS, M.D. (*Medical Record*, Dec. 28, 1901, p. 1,003).

Guiteras reports another series of cases improved by this method of treatment. The results were gratifying. The contractile power of the vesical sphincters is not reduced by the Bottini operation, but on the contrary is increased, and the author knows of but one case in which incontinence appeared for the first time after the prostotomy. The amount of residual urine is reduced; and further, the patients are not always incapacitated sexually by the operation, as is usually supposed. As evidence the author mentions the case of a patient, 67 years old, who was operated upon two years ago. He was then suffering from severe urinary symptoms, and had six ounces of residual urine. Recently he presented himself for treatment for a venereal disease which he had contracted during intercourse. He felt himself cured of his prostatic trouble.

The best anesthetic in these operations is nitrous oxide gas, though ether was employed in most of these cases, for reasons not stated.

Of this series there were two classes of cases: Those who had suffered a long time, had considerable retention, and remarkably enlarged prostates, and those who had had attacks of retention, the prostate not much enlarged, as felt by the rectal touch, and the urethra not much elongated, though there was an impediment in the posterior portion. Enucleation should have been performed in the first class of cases, but the operation was not performed either because of the fears of the patients or the operator that they could not survive it owing to the damaged condition of the kidneys.

The second class of cases was suitable for the Bottini, and were properly

operated upon by it, with benefit to all but one. With this exception, all the patients said they felt better after operation, and in every case the amount of residual urine was diminished by quantities varying from two to seven ounces. Patients who could not pass urine at all, having suffered complete retention, were able to empty their bladders, with the exception of a few ounces.

A. L. W.

The Diagnosis and Surgical Treatment of Renal Tuberculosis.—F. TILDEN BROWN, M.D. (*Boston Medical and Surgical Journal*, May 30, 1901, pp. 513-520).

Brown emphasizes the importance of making an absolutely correct diagnosis in cases of renal tuberculosis. It is not enough to make a diagnosis of pyelitis, nephritis, or cystitis, but the etiology must be sought for. In urinary cases in general, urinary analysis should mean as careful a routine search for tubercle bacilli as is customarily given to the other formed elements of a sediment. When this is done, wholly symptomless cases of the disease will at times be discovered. Suspicion should be verified and the smegma bacillus excluded by getting the bladder urine through a catheter, and then by cystoscopic uretheral catheterization, locating the lesion in the bladder or kidneys. The author's double-barrelled ureteral cystoscope is recommended as the most accurate and simple way of doing this in either sex. Especial care must be taken to eliminate the smegma bacillus from urinary specimens examined.

Sometimes the subjective symptoms are quite pronounced, even in the early stages of the disease. A dull aching in the lumbar region is significant; equally so a much more acute pain referable to the kidney or ureter. Occurring as crises, associated with nausea and vomiting, renal colic or gravel calculus is most apt to be thought of. Too frequent urination may be the first symptom.

Objectively the principal symptoms are a kidney which is larger and more tender than normal, as well as all grades of pyuria and hematuria, besides a just appreciable or well marked diurnal variation in temperature; loss of color and weight; a reaction to tuberculin; finally the presence of tubercle bacilli in the urine derived directly from one or both kidneys.

A great deal of value is placed upon the injection of tuberculin. This would be employed where a unilateral pyelonephritis was found in an individual giving some other suggestions of urinary tuberculosis, but at the same time running a nearly normal temperature. Should a fairly typical reaction here follow the injection, and could tuberculous foci be excluded from other parts of the body, the author would feel quite sure that guinea pigs inoculated by sedimental urine from this individual kidney would develop tuberculosis.

For the operation, if the heart is unquestionably sound, chloroform is the anesthetic preferred; otherwise nitrous oxide gas and ether.

During a nephrectomy for renal tuberculosis, if the ureter is found diseased down to a point below the first sacral vertebra, it is not always wise that total extirpation then, or at a later operation, be done. Observations tend to the inference that a considerable length of tuberculous ureter may be left with comparative safety, because after the removal of the diseased kidney, being in a functionless state of repose, this particular focus is amenable to curative systemic processes. If total removal, however, did not necessitate such an increased operative exposure, the radical removal of all affected tissues would better satisfy the surgical indications here, just as well as in dealing with any tuberculosis.

If a ureter is found diseased from kidney to bladder, it might be better to remove the lower half, giving the proximal half a temporary cutaneous implantation, there to drain the kidney until an early, favorable time for nephrectomy. In this way the services of both kidneys would be available in convalescence from one operation.

Before operation should efforts to ascertain the state of the kidneys be unavailing, then the epicystotomy done for drainage should be utilized to at once lead a small flexible ureteral catheter into each ureter mouth, whatever treatment is immediately afterwards to be given the tuberculous bladder lesions. Artificial illumination, like that of the electric headlight, is almost indispensible for the accomplishment of this procedure.

A. L. W.

A Case of Small White Kidney.—W. H. BRAZIL, M.D., D.P.H. (*Medical Chronicle*, Manchester, England, June, 1901, p. 187).

Brazil reports a typical case of small white kidney, which on account of its rarity is interesting: A boy, 15, was first seen suffering from edema of the feet and eyelids, frequent attacks of headache and sickness, and gradually increasing weakness and dyspnea. Ten years previously he had had scarlatina, without any evidences of acute nephritis. Eight years later, however, when under treatment for fracture of the thigh, the urine was found to contain albumin.

When first seen, had edema of the eyelids, chin and adjoining part of cheeks. No ascites. Pulse 88 and of high tension. Heart much hypertrophied. Urine, specific gravity 1016, acid, albumin one-half, no sugar. Subsequent examinations of the urine showed the following characters: Amount varied from 20 to 52 ounces per diem. Sp. Gr. varied from 1007 to 1015. Urea from 0.5 to 1.6 per cent. Amount of albumin varied from ¼ to ⅔. Amount of serum albumin on one occasion was 0.175 per cent, while that of serum globulin was 0.025 per cent., giving a proteid quotient of 7. Hyaline and granular casts were found. With the ophthalmoscope, both eyes presented the most typical appearances of albuminuric retinitis and papillitis.

The patient gradually became worse, cardiac dulness increased, and he had several attacks of pericarditis. Urine became more scanty, universal anasarca appeared, orthopnea set in and he died in epileptiform convulsions six months after the writer first saw him.

On autopsy both kidneys were smaller than normal, extremely pale, almost white in color; surface irregularly contracted, producing a lobulated appearance. Capsule peeled off easily. On section, the cut surface was pale, and showed yellowish-white patches in places. No cysts. Cortex much atrophied, especially in places corresponding to surface depressions. Microscopic examination showed excess of fibrous tissue with degeneration of secreting structure everywhere. Convoluted tubules were empty or showed degenerated epithelium. Arterioles distinctly thickened.

Clinically the most noteworthy feature was the combination of the edema, pallor, and highly albuminous urine, characteristic of the large white kidney, with the cardiac hypertrophy and high tension pulse associated with the small red kidney.

Difference of opinion exists as to the origin of the small white kidney, many considering it to represent the last stage of the large white kidney. Others

contend for the essential unity of the small white and the small red kidneys, though the first view seems to be borne out by the evidence of the few cases reported.

A. L. W.

Primary Epithelioma of the Bulbous Urethra.— W. P. MONTGOMERY, M.A., M.B., F.R.C.S. (*Medical Chronicle*, Manchester England, June, 1901, p. 190).

The author reports the twelfth recorded case. The patient was 54 years old, no history of gonorrhea or syphilis. For last four months had gradually increasing difficulty in micturition, occasionally passing a few drops of blood before and after the act, while straining. For three months there had been a swelling in the perineum which had been growing slowly.

On examination this was a hard mass, two and one-half inches in its long antero-posterior diameter, and one inch transversely, apparently attached to the bulbous urethra. It could be felt in front through the scrotal tissues fixed to the corpora cavernosa and corpus spongiosum, and could be moved to some extent from side to side with them. The posterior limit was well defined in the perineum. Skin and subcutaneous tissues were somewhat adherent at the posterior limit. The skin itself, however, was unbroken, and showed no evidence of a previous sinus or fistula.

Per rectum, prostate was somewhat hypertrophied, though not more than might be expected at the age of the patient. The posterior limit of the tumor could not be made out, and the space intervening between the apex of the prostate and the tumor—the site of the membraneous urethra—was certainly normal. There was no fluctuation over the perineal swelling. Patient was compelled to micturate every two hours, with nothing in the nature of a "stream." Urine was acid, contained a trace of albumin, but no blood.

No instrument could be passed. Passage of the sound was arrested at the anterior border of the tumor, and persistence was followed by free hemorrhage. Perineal incision was performed under chloroform for drainage of bladder, but that had no effect on stopping the growth of the tumor. There was no sign of abscess formation. At that time the possibility of the growth being a cancer occurred for the first time. A piece of the growth was removed and the diagnosis of squamous carcinoma was confirmed.

To remove the entire mass was impossible, for it extended in all directions. The perineal opening was kept in action.

Six months later the perineal surface of the tumor broke down, leaving a deep ulcer which discharged pus and blood. Patient was markedly cachectic. The perineum was soon replaced by a large cavity with irregular, bleeding walls, and almost large enough to admit a closed fist. The femoral vein became thrombosed, and the patient died exhausted eight months after he was first seen.

Sections made after death showed that the ulcer was a typical squamous-celled carcinoma; the root of the penis was involved in this growth with a sharp line of demarcation between it and the normal healthy penile urethra; the ulceration of the membranous urethra was limited equally sharply within a quarter of an inch of the apex of the prostate; the prostate and its urethra were not involved.

Clinically the tumor was to be differentiated from (1) carcinoma of one of Cowper's glands, (2) carcinoma of the prostate, (3) sarcoma. It was evident that the prostate and the membranous urethra were not involved.

A. L. W.

Syphilis as a Non-venereal Disease.—L. DUNCAN BULKLEY, M.D. (*Jour. Am. Med. Ass'n.*, April 6, 1901, p. 933).

Bulkley pleads in strong terms for the consideration of syphilis as a non-venereal disease, owing to the immense number of patients infected in a non-sexual manner. Legal restraint, through the action of health boards, is called for, as in other contagious diseases. If syphilis can become known as a non-venereal disease, it will not be so difficult to secure necessary legislation that will act as a protectant to the innocent.

The three great classes of "syphilis insontium" are, (1) marital syphilis, (2) hereditary syphilis, (3) extragenital, innocent syphilis. In the private practice of the writer, he found that in fully 50 per cent. of the women suffering from syphilis, the disease was acquired in a perfectly innocent manner, while among the married females the percentage of innocent infections would be 85 per cent. or more.

Of hereditary syphilis the aspect is darker. In the Moscow Hospital, Russia, of 2,002 births, there were 1,425 deaths; that is, 71 per cent. of the children born there of syphilitic parents died. From the standpoint of loss of population, this subject is worthy of the attention of government authorities.

It should be quite as criminal to transmit syphilis wittingly as it is to communicate smallpox, scarlatina or diphtheria. If syphilis can be included in the list of contagious diseases which the health boards can control, proper legislation will follow, as the profession and the public become more enlightened as to the real nature of syphilis and the real danger to the public from it.

A. L. W.

Some Observations in Renal Surgery.—W. H. ALLPORT, M.D. (*Jour. Amer. Med. Ass'n.*, April 6, 1901, p. 947).

Allport reports a number of cases in which errors of diagnosis and treatment were made. The paper is called a contribution to the natural history of error, and the writer claims as his apology for the paper, that we learn more from defeat than from victory.

Fourteen cases are reported. The writer summarizes the errors with which the cases seem to have been fraught as follows: 1. The surgeon should not attach too great weight to the recollections or the subjective symptoms of the patient, unless borne out by the physical signs. 2. On the other hand due weight should be given to statements made by intelligent patients, especially in cases where the objective testimony is abundant, but confusingly contradictory. Every legitimate opportunity should be offered the patient to establish a sequence of disease. The history taking should also be done with the greatest care. 3. It is an error in pathologic conditions to place too great reliance on relations normal to the healthy individual. No diagnosis of tumor or structure is complete until consideration has been given to the possibility of encroachment by organs or growths on the normal sites of organs, which *prima facie* evidence would lead us to believe to be the ones involved. 4. It is an error even in the presence of conditions which seem pathognomonic, to neglect every diagnostic resource, and to follow up each resource faithfully to its logical conclusion. 5. Among operative errors may be noted the failure to properly care for the ureter in two of the cases. The ureter should be litigated with catgut and brought separately into the wound after cauterizing with carbolic acid; or better still, should be inverted a short distance and stitched. Kidney stumps

should not be ligated with silk. Too deep incisions into the kidney structures are dangerous and jeopardize the subsequent integrity of the pelvis and ureter. The kidney and the operation wound should not be closed primarily after nephrotomies. Drainage for a few days at least is much safer and may save a subsequent nephrectomy. A kidney riddled with sinuses is best removed; conservative measures only lead to another operation. It is an error to base an incision on any preconceived idea of diagnosis; rather follow Tait's rule that "the kidney is best reached by the most likely route."

A. L. W.

Total Extirpation of the Prostate for Radical Cure of Enlargement of That Organ.—By P. J. FREYER, M.A., M.D., M.Ch. (*British Medical Journal*, July 20, 1901, p. 125.)

Freyer reports four cases in which he performed total extirpation of the prostate, with successful result in all. The age of the patients varied from 62 to 69 years, and in all of them the catheter had to be used for periods varying from six months to four or five years previous to operation.

Suprapubic cystotomy is first performed, and after nipping the mucous membrane covering the lobes of the prostate, the lobes are enucleated separately, or together, and then stripped off the urethra, which, with its enveloping tissues, is left intact. The ejaculatory ducts are left uninjured when the lobes come away separately, or the urethra is pushed beneath them. When the prostate comes away whole, it is not known what happens to these ducts, though at the advanced age of the patients this is not a matter of great importance.

In enucleating the prostate out of its sheath, the fibrous bands that pass between the sheath and the true capsule are torn through, but the prostatic plexus of veins and large branches of arteries are left behind only the smaller vessels passing to and from the prostatic substance through the capsule being severed. This accounts for the trifling hemorrhage which takes place in this operation in comparison with the profuse bleeding which sometimes occurs in various forms of partial prostatectomy when the prominent parts in the bladder are cut, or torn off by forceps, the large veins and arteries being thus opened up.

The most remarkable feature of this operation, in the estimation of the author, is the complete restoration of the power of volunary micurition after habitual catheterism had been employed for periods of time varying from six months to five years.

A. L. W.

Sexual Neurasthenia in the Male; a Plea for a More Accurate Use of the Term; Treatment of the True Forms with a Citation of Cases.—By RAMON GUITERAS, M.D. (*Medical News*, July 13, 1901, page 52).

Guiteras pleads for a more accurate use of the term sexual neurasthenia, and believes it should be restricted to those cases of neurasthenia in which a morbid condition of the genital apparatus exists, a condition which is demonstrated to be the source of the systemic disturbance, by the fact that its cure is quickly followed by the disappearance of the neurasthenia. A thorough examination of the urethral tract should be made in every case whether the patient calls attention to this tract or not, because the urethral symptoms may be masked by the general symptoms, or they may be absent altogether.

It is generally believed that the principal rôle in the causation of the neurasthenic state is to be attributed to the affections of the prostate, seminal vesicles

and spermatic cord. Enough prominence has not been given, the author states, to the urethra as the seat of the trouble in these cases.

The final proof of a correct diagnosis is the therapeutic test, and it has often been possible to correct the neurasthenic state by an intelligent application to the lesions in the urethra.

The treatment consists of the removal of the genital lesion and the eradication of the secondary effects. For the former the treatment of chronic gonorrhea and its complications is indicated. The source of irritation may be congenital or acquired. Among the former are a tight prepuce, partial or complete phimosis, small meatus or congenital stricture behind it, hypospadias or epispadias, and undescended testicle. Among the acquired are chronic urethritis, chronic prostatitis, chronic seminal vesiculitis, chronic epididymitis, and also varicocele, tumors of the prostate and of the testicle, traumatism of the genital organs, and defective innervation of the sexual center of the spinal cord. To these are also added contributing causes, as sedentary life, constipation, hemorrhoids, ulcer of the rectum, prolonged bicycle riding, onanism, masturbation, and above all, *coitus reservatus vel interruptus*. These contributing causes must cease to act if distinct and permanent benefit is expected to be gained by treatment.

In addition the general health must be looked after, especially by the use of exercise, baths, regulation of the bowels, massage, and regulation of the diet. Golf is the best form of exercise, sailng, fishng and horseback riding (with the proper kind of saddle) being also valuable. For office treatment static electricity has been of value and is recommended. A. L. W.

Masturbational Neuroses.—By W. C. KRAUSS, M.D. (*Medical News*, July 13, 1901, page 58).

Krauss decries the tendency in certain quarters to defend the habit of masturbation and to champion those who practice it. He sees but two redeeming features in the practice: First, in this age of commercialism it is cheap and within the reach of all; second, it helps to fill the coffers of the otherwise needy and struggling physician.

The habit in certain cases acquires a power that is dominating and destructive to body and mind. The causes of this are either an innate morbid strength of the reproductive instinct, or much more frequently an innate morbid weakness of the controlling faculties, or a lack of the inherent brain stability, or an incapacity of inorganic repugnance to what is unnatural. These weaknesses are apt to occur in the children of neurotic families.

Heredity and temperament are undoubtedly the true explanation of the opposing statements that are made that the habit seldom does much harm, and on the other hand, that it is the root of most of the evils of boyhood, and that it ruins the health of those who indulge in it.

The habit seems to have an opposite effect upon the sexes, dulling the mental and making clumsy the physical exertions of the male, while in the female it quickens and excites the physical and psychical movements. The male is rendered hypoesthetic, the female hyperesthetic. The neurosis following is neurasthenia, the psychosis, hebephrenia.

Treatment must be directed to the removal of the practice, otherwise a cure of the functional neuroses is impossible. The prognosis in extreme cases is not bright, especially when coupled with a neurotic family history. A. L. W.

The Preferable Method of Uretero-Ureteral Anastomosis.—By J. W. BOVEE (*Journal of the American Medical Association*, July 27, 1901, page 254.)

Bovee discusses the various operations devised for suturing the severed ends of the ureter. The four different methods, end-to-end, end-in-side, end-in-end, and lateral or side-to-side, are discussed. The severed ends of ureters have been united thus far 33 times, without evidence of ureteral incompetency as a result. The side-to-side anastomosis has been done experimentally on animals, but it has probably never been done in man. The end-to-end, or the end-in-end methods are applicable in every case in which the other methods might be employed with a single exception. The reverse cannot be said. The end-to-end plan is preferable, with the end-in-end method next to it as the method of choice. With these two methods the surgeon should be able to repair any injury to the ureter, except of its very lowest part, involving a loss not exceeding three inches. A. L. W.

A Statistical Digest of Epithelioma of the Penis.—By F. D. PATTERSON, M.D., (*University of Pennsylvania Medical Bulletin*, July, 1901, page 157).

Patterson concludes after an exhaustive review of the literature of this subject that epithelioma is by far the most frequent form of carcinoma of the penis, and that its frequency is about 2 per cent. of all cancers. Phimosis is a strong predisposing factor by causing chronic irritation, causing chronic balanitis or posthitis, or both. There is no record of a single case occurring among the Jews. As a rule epithelioma is more frequent after middle life, though this rule has its exceptions. One case is reported where the patient was but 22 years old.

The syphilitic virus has absolutely nothing to do with epithelioma, the scar of the old specific lesion being nothing more than an area of decreased resistance or a cause of chronic irritation. Traumatism is a predisposing factor by causing an area of decreased resistance. The question of the contagiousness of epithelioma is still to be decided. The growth usually begins in the glans or prepuce, and urethral origin is very rare. The symptoms vary with the location of the growth. Slight hemorrhage may occur, though severe bleeding is very rare.

Extension of the disease is either through the lymphatics or the cavernous tissues of the penis. The latter is rare; for the reason that the fibrous tissue sheath of the penis resists the invasion of the growth for a long time, becomes thickened, and as a result the epithelioma eats its way slowly. Visceral metastasis is very rare, though not unknown. The prognosis is favorable in the precancerous stage if radical treatment be at once instituted; later it is only guardedly so. The only safe treatment in any stage consists in the thorough eradication of the diseased area, and of all lymphatic glands that are involved.
A. L. W.

A Contribution to the Surgery of the Kidney.—By BAYARD HOLMES, M.D. (*Journal of the American Medical Association*, July 20, 1901, page 172).

Holmes reports two cases of disease of the kidneys simulating gall-stones. One of the cases was that of a cystic kidney, in which the tumor made itself manifest just below the free border of the liver, and by pressure on the gall-bladder, produced symptoms resembling those of stone. On operation the gall-bladder was found normal, but the diseased kidney was found and removed.

The patient, a woman 35 years old, made a successful recovery, and has been free from symptoms for more than a year and a half.

The second case was that of a movable kidney which also produced symptoms by pressure on the gall-bladder. Operation was performed, the gall-bladder found normal, and the kidney sutured to the posterior wall, with complete success. A. L. W.

A Suggestion for the Treatment of Enuresis in Females.—By G. C. PARNELL, M.R.C.S. (*British Medical Journal*, Jan. 11, 1902, p. 72).

Parnell advocates the employment of strong solutions of silver nitrate to the neck of the bladder and the urethra for this condition. By means of a probe covered with cotton wool, a solution of silver nitrate (30 grains to the ounce, gradually increased) is applied to the urethral canal, allowing it to remain about ninety seconds. Improvement is almost immediate, and is continuous if the applications are kept up for some time at intervals of three or four days.

In order that the solution shall come into contact with the entire urethral canal, the author has devised a small dilator, which permits of the application to every part of the canal.

Five cases are reported in which the remedy was applied with more or less success. A. L. W.

Blood in the Urine as a Symptom, and the Diagnosis of Its Source.—By JOSEPH WIENER, JR., M.D. (*New York Medical Journal*, March 9, 1901).

Wiener discusses this subject at great length, paying especial attention to the diagnosis of the source of the hemorrhage. Cystoscopy is of great value in determining this question, but its use is impracticable where there is stricture of the urethra, tendency to urethral sepsis, and profuse hemorrhage from the prostate or bladder. The ureteral catheter is not so easy, or so harmless, as cystoscopy, nor are the results so satisfactory.

The previous history is of importance, as is the age of the patient, and the time at which the blood appears in the stream of urine. In early life the hemorrhage may be due to stone in the bladder, tuberculosis of the prostate or of the bladder, some of the sequelæ of gonorrhea, sarcoma of the kidney, or a kidney lesion following one of the exanthemata. In adult life, urethral stricture and its results, stone and new growths in the bladder or kidney. In old age enlarged prostate, or a stone in the bladder, or sometimes cancer of the bladder. Blood coming from the urethra between acts of micturition is derived from the urethra. Fluid blood appearing at the beginning of the stream, comes from the prostate or deep urethra. A large amount of blood from the prostate may find its way into the bladder and become mixed with the urine. A clot in the beginning of the stream is from the urethra, prostate, or bladder. The same is true of that blood which appears at the end or toward the end of clear urination. Blood from the kidney is intimately mixed with the urine. In tumor of the bladder the hemorrhage is most profuse at the end of the stream.

Frequency and duration of the attacks and the effects of complete rest and exercise are important to note. In renal hematuria, or stone, and in movable kidney, the hemorrhage appears and disappears suddenly. After a short interval, a long thin clot may appear, followed again by profuse hemorrhage.

Chemically the relation between the amount of albumin and hemoglobin is of great importance in diagnosing the source of the hemorrhage. If there is a greater proportion of albumin than 1 to 16 of hemoglobin, it may be inferred that there

is albuminuria as well as hematuria, and that in all probability the hemorrhage is of renal origin. Microscopically the finding of many red blood cells showing the fragmentation first pointed out by Gumprecht is diagnostic of a renal source of the hemorrhage. In addition the finding of pus, mucus, epithelial cells, tuberculous material, portions of tumors and micro-organisms will be of value.

The various kidney lesions producing hemorrhage are also carefully discussed at length. The author prefers to make the diagnosis, if possible, without the use of instruments. Older methods should be followed before we fall back upon the newer ones. A. L. W.

NOTICE.

Taking into consideration the fact that the general international medical congress will meet in Madrid in 1903, the International Dermatological Congress which was originally meant to take place that same year in Berlin, has been postponed till 1904 and will then meet in September, presided by Prof. E. Lesser. The general secretary of the congress is Dr. O. Rosenthal, Berlin.

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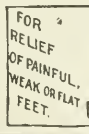

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